

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the deceased's certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201				CERTIFICATE OF DEATH			
1. DECEASED-NAME (Type or print) First Middle Last Jacqueline M Abell				2a. DATE OF DEATH Month Day Year July 16 1968			
3. SEX Female		4. RACE White		5. DATE OF BIRTH 9 June 1926		6. AGE (In years last birthday) 42 YRS.	
7a. BIRTHPLACE (State or foreign country) North Carolina		7b. CITIZEN OF WHAT COUNTRY? U S A		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Pr. Geo. Md.	
10. CITY OR TOWN OF DEATH Cheverly		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Pr. Geo. Gen. Hosp.		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Nurse		12b. KIND OF BUSINESS OR INDUSTRY hospital	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland		13b. COUNTY Pr. Geo.		13c. CITY OR TOWN Hyattsville		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
13e. STREET AND NUMBER 7102 Wells Pkwy		14. FATHER'S NAME First Middle Last Leo H Hanratty		15. MOTHER'S MAIDEN NAME First Middle Last Marie Connors			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown no		16b. SOCIAL SECURITY NO.		17. INFORMANT Address Dr James E Abell Hyattsville, Md.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Agramulocytosis. DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Pneumonia, right lower lobe. DUE TO, OR AS A CONSEQUENCE OF (c) Moniliosis, upper esophagus. PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) 1343							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Port 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that (I) (the hospital) attended the deceased from February 19 68 , to July 16, 1968 , that (I) (we) last saw the deceased alive on July 16, 1968 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <i>[Signature]</i>				DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED July 16, 1968	
22d. PHYSICIAN'S NAME (Type) Ohannes Sahakyan, M. D.				22e. ADDRESS 6001 Landover Rd., Cheverly, Md. 20785			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 7/19/68		23c. NAME OF CEMETERY OR CREMATORY Ft Lincoln Cemetery		23d. LOCATION (City or Town) (County) (State) Colmar Manor Pro Geo Md.	
24. FUNERAL DIRECTOR F.. Gasch's Sons				ADDRESS Hyattsville, Md.		25a. REC'D BY REGISTRAR DATE JUL 19 1968	
						25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>	

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VR A15
30M REV. 1-68

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

Item 5 Film 0402 7/10/68

CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or print) Royal Leon Allen			2a. DATE OF DEATH Month July Day 1 Year 1968			2b. HOUR 9:25 AM									
3. SEX Male		4. RACE White		5. DATE OF BIRTH June 23, 1896		6. AGE (in years last birthday) 72 YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		IF UNDER 24 HRS. HOURS MIN.					
7a. BIRTHPLACE (State or foreign country) Virginia		7b. CITIZEN OF WHAT COUNTRY? U. S. A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Prince Georges Md.									
10. CITY OR TOWN OF DEATH Upper Marlboro			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) --			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Retired Carpenter			12b. KIND OF BUSINESS OR INDUSTRY Pr. Geo County Gov.						
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Md.			13b. COUNTY Pr. Geo's			13c. CITY OR TOWN Upper Marlboro		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER --					
14. FATHER'S NAME First William L. Middle Allen Last Allen			15. MOTHER'S MAIDEN NAME First Della Middle -- Last Snead			16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes give war or dates of service) ----						16b. SOCIAL SECURITY NO. 214-12-7792		17. INFORMANT Address Same as Item Mrs. George Wesley Allen-#10	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial Infarction 4109 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last 4201 (b) Arteriosclerotic Cardiovascular Disease DUE TO, OR AS A CONSEQUENCE OF (c) -- APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH															
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a) Cirrhosis															
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?							
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)											
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State											
22a. I certify that (I) (this hospital) attended the deceased from Oct. 1963 , to 7/1 , 19 68 , that (I) (we) last saw the deceased alive on 7/1 19 68 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.															
22b. SIGNATURE A. Clark Holmes M.D.				DEGREE		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED 7/1/68							
22d. PHYSICIAN'S NAME (Type) A. Clark Holmes, M. D.				22e. ADDRESS Upper Marlboro, Md. 20870											
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 7/5/68		23c. NAME OF CEMETERY OR CREMATORY Trinity Cemetery				23d. LOCATION (City or Town) (County) (State) Upper Marlboro P.G. Md.							
24. FUNERAL DIRECTOR ADDRESS Ritchie Bros. Upper Marlboro, Md.				25a. REC'D BY REGISTRAR JUL - 9 1968		25b. REGISTRAR'S SIGNATURE J. Charles Judge									

211-12-1125

U.S. GEOLOGICAL SURVEY

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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10393										DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										10404									
1. DECEASED-NAME (Type or print)										2a. DATE OF DEATH										2b. HOUR									
Henry Lee Arnold										Month July Day 22 Year 1968										4:50p M									
3. SEX			4. RACE			5. DATE OF BIRTH			6. AGE (In years last birthday)			IF UNDER 1 YEAR MONTHS			IF UNDER 24 HRS. HOURS			IF UNDER 24 HRS. MIN.											
Male			White			12/19/08			59																				
7a. BIRTHPLACE (State or foreign country)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH																				
Md			U S A						Prince George's																				
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)			12b. KIND OF BUSINESS OR INDUSTRY																				
Cheverly			Prince George's Gen. Hosp.			Pipefitter			Wash Terminal																				
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE			13b. COUNTY			13c. CITY OR TOWN			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET AND NUMBER																	
Maryland			Prince Geo. Mt. Rainier						YES			3210 Upshur St.																	
14. FATHER'S NAME First Middle Last					15. MOTHER'S MAIDEN NAME First Middle Last																								
Leister Arnold					Mary E Miller																								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) (If yes give war or dates of service)					16b. SOCIAL SECURITY NO.					17. INFORMANT Address																			
no										Violet L Arnold					Mt Rainier, Md.														
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH																			
PART I. DEATH WAS CAUSED BY:																													
IMMEDIATE CAUSE (a) <u>Acute myocardial infarction</u>																													
DUE TO, OR AS A CONSEQUENCE OF (b) <u>Broncho pneumonia</u>																													
DUE TO, OR AS A CONSEQUENCE OF (c) <u>Arterial stenosis (characteristic)</u>																													
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a)																													
<u>Bilateral Pul. emboli</u>																													
19a. DATE OF OPERATION					19b. CONDITION FOR WHICH OPERATION WAS PERFORMED					20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>					20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes														
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)					21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19					21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)																			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>					21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)					21f. LOCATION Street or R.F.D. No. City or Town County State																			
22a. I certify that (I) <u>George Hageage, M.D.</u> attended the deceased from <u>7-11</u> , 19 <u>68</u> , to <u>July 22</u> , 19 <u>68</u> , that (I) <u>we</u> lost the deceased alive on <u>7-22</u> , 19 <u>68</u> , and that in (my) <u>work</u> opinion death occurred on the date and hour and from the causes stated above, (I) <u>we</u> (did) <u>did not</u> view the body after death.																													
22b. SIGNATURE <u>George Hageage, M.D.</u>										22c. DATE SIGNED <u>7-23-68</u>																			
22d. PHYSICIAN'S NAME (Type) <u>George Hageage, M.D.</u>										22e. ADDRESS <u>3717 38th Ave., Cottage City, Md.</u>																			
23a. BURIAL, CREMATION, REMOVAL (Specify)			23b. DATE			23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION (City or Town) (County) (State)																				
Burial			July 25, 1968			Mt Herbron cemetery			Winchester Fredrick			Va																	
24. FUNERAL DIRECTOR					ADDRESS					25a. REC'D BY REGISTRAR					25b. REGISTRAR'S SIGNATURE														
F. Gasch's Sons					Hyattsville, Md.					DATE <u>JUL 26 1968</u>					<u>Charles Judge</u>														

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
10396 See birth cert Item 7a 8/19/68 rts									
MEDICAL EXAMINER'S CERTIFICATE OF DEATH									
1. DECEASED-NAME (Type or Print) First Middle Last Candy Ann Austin						2a. DATE KNOWN OF ESTI- DEATH MATED <input checked="" type="checkbox"/> Month Day Year 7-17-68 19 11:45am		2b. HOUR	
3. SEX Female		4. RACE White		5. DATE OF BIRTH Feb. 26 1968		6. AGE (In years last birthday) YRS. 4 MONTHS DAYS HOURS MIN		2c. DATE PRONOUNCED DEAD Month Day Year 7 17 68 19 11:45am	
7a. BIRTHPLACE (State or foreign country) Maryland		7b. CITIZEN OF WHAT COUNTRY? U. S.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Prince George's Md.			
10. CITY OR TOWN OF DEATH Cheverly				11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Prince George Hospital		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland				13b. COUNTY Prince George Mt. Rainier		13c. CITY OR TOWN YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13d. STREET AND NUMBER 3802 33rd. Street	
14. FATHER'S NAME First Middle Last BRUCE WAYNE AUSTIN				15. MOTHER'S MAIDEN NAME First Middle Last CAROLYN S. ASHLAND					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO				16b. SOCIAL SECURITY NO. (If yes give war or dates of service) *****		17. INFORMANT ADDRESS BRUCE W. AUSTIN FATHER SAME AS ABOVE			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 795X DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) SDII DUE TO, OR AS A CONSEQUENCE OF (c)								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 795.5									
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>									
ACTUAL SIGNATURE EXAMINER'S NAME (Type) John Kehoe MD				M.D. Riverdale, Md.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		22b. DATE SIGNED 7-18-68	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE 7/19/68		23c. NAME OF CEMETERY OR CREMATORY EVERGREEN		23d. LOCATION (City or Town) (County) (State) ROANOKE VIRGINIA			
24. FUNERAL DIRECTOR F. GASCH'S SONS				ADDRESS HYATT'SVILLE, MARYLAND		25a. REC'D BY REGISTRAR DATE JUL 22 1968		25b. REGISTRAR'S SIGNATURE J Charles Judge	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

10397

10406

1. DECEASED-NAME (Type or print) Frederick H. Ball			2a. DATE OF DEATH Month July , Day 10 , Year 1968			2b. HOUR 10 P.M.			
3. SEX Male		4. RACE Caucasian		5. DATE OF BIRTH Feb. 5, 1881		6. AGE (In years last birthday) 87 YRS.		IF UNDER 1 YEAR MONTHS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (State or foreign country) Washington D.C.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Prince George's Md.			
10. CITY OR TOWN OF DEATH Cheverly		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Prince Geo. Gen'l Hospital		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Retired		12b. KIND OF BUSINESS OR INDUSTRY Railroad			
13a. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) STATE Maryland		13b. COUNTY Prince George's		13c. CITY OR TOWN Seat Pleasant		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 6195 Central Ave.	
14. FATHER'S NAME First Middle Last HENRY S BALL			15. MOTHER'S MAIDEN NAME First Middle Last MARY P STREET						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) NO (If yes give war or dates of service) NO		16b. SOCIAL SECURITY NO. 719/03/1760		17. INFORMANT Address Lawrence C Ball POBox 26I Edgewater Md					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute cardiac failure 2509 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerotic heart disease DUE TO, OR AS A CONSEQUENCE OF (c) Diabetes mellitus -								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) 260x Chronic anemia (Klinefelter's disease)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) physician attended the deceased from 4/2 , 19 68 , to July 10 , 19 68 , that (I) yes last saw the deceased alive on July 10 , 19 68 , and that in (my) own opinion death occurred on the date and hour and from the causes stated above, (I) yes (did) not view the body after death.									
22b. SIGNATURE 				DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED 7/14/68			
22d. PHYSICIAN'S NAME (Type) David Anders, M. D.				22e. ADDRESS 3308 Dodge Park Rd., Landover, Md. 20785					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 7/13/68		23c. NAME OF CEMETERY OR CREMATORY Mt Olivet Cemetery		23d. LOCATION (City or Town) (County) (State) Washington D.C.			
24. FUNERAL DIRECTOR ADDRESS Lee Funeral Home 300 4th St NE D.C.				25a. REC'D BY REGISTRAR JUL 15 1968		25b. REGISTRAR'S SIGNATURE 			

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Male

Caucasian

Feb. 2, 1901

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Other names

Chavris

Prince Geo. Genl. Hospital

Harvard

Prince George's Genl. Hospital

also General

1901

88

July 10, 1901

July 10, 1901

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David Anders, M.D.

1300 Lodge Park N.W., Langley, Va.

July 1, 1908

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

10398

CERTIFICATE OF DEATH

10407

1. DECEASED-NAME (Type or print) Harry Arthur Barbour			2a. DATE OF DEATH July Month 17 Day 1968 ar			2b. HOUR 11:45 AM			
3. SEX male		4. RACE Caucasian		5. DATE OF BIRTH 7-9-1892		6. AGE (In years lost, birthday) 76 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (State or foreign country) New York		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Prince Georges County Md.			
10. CITY OR TOWN OF DEATH Oxon Hill		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) 4925 Deal Drive		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) body 1st		12b. KIND OF BUSINESS OR INDUSTRY			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland		13b. COUNTY Prince Georges		13c. CITY OR TOWN Oxon Hill		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 4925 Deal Drive	
14. FATHER'S NAME Harry A. Barbour			15. MOTHER'S MAIDEN NAME Sarah Tomlinson			16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) (If yes give war or dates of service) No			
16b. SOCIAL SECURITY NO. 225 46 4794			17. INFORMANT Paul H. Byers, Son-in-law, 6845 Summitt Rd. McLean, Va.						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinomatosis 174X DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Carcinoma of breast DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 10y4.									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 170X									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from July 16 , 19 68 , to July 17 , 19 68 , that (I) (we) last saw the deceased alive on July 16 , 19 68 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE Herbert Wisotsky, M.D.				22c. DATE SIGNED 7-17-1968		22d. PHYSICIAN'S NAME (Type) Herbert Wisotsky, M.D.			
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE 7-20-1968		23c. NAME OF CEMETERY OR CREMATORY St. Barnabas Cemetery		23d. LOCATION (City or Town) (County) (State) Oxon Hill, Maryland			
24. FUNERAL DIRECTOR Joseph Gawler's Sons, Inc., 5130 Wisc. Ave. N.W., Wash., D.C., 20016				25a. REC'D BY REGISTRAR DATE JUL 22 1968		25b. REGISTRAR'S SIGNATURE Charles Judge			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

Continued - John Kehler M.D. - Pepsin - 10/1/68

MEDICAL CERTIFICATION

1. DECEASED-NAME (Type or print) First Middle Last EDITH LORD BARCLAY			2a. DATE OF DEATH 7 Month 12 Day 68 Year		2b. HOUR 8A M
3. SEX FEMALE	4. RACE WHITE	5. DATE OF BIRTH APRIL 2, 1877		6. AGE (In years last birthday) 91 YRS.	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.
7a. BIRTHPLACE (State or foreign country) N. H.	7b. CITIZEN OF WHAT COUNTRY? U. S. A	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH PRINCE GEORGE Md.	
10. CITY OR TOWN OF DEATH BOWIE		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) 12107 LERNER PL		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) HOUSEWIFE	12b. KIND OF BUSINESS OR INDUSTRY ILLUSTRATOR
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE MD		13b. COUNTY P. G.	13c. CITY OR TOWN BOWIE	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET AND NUMBER 12107 LERNER PL
14. FATHER'S NAME First Middle Last GEORGE W. LORD			15. MOTHER'S MAIDEN NAME First Middle Last MARY JOHNSON		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown (If yes give war or dates of service) NO		16b. SOCIAL SECURITY NO. 001-36-1174	17. INFORMANT RALPH E. BARCLAY		Address SAME #13
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CEREBRAL VASCULAR OCCLUSION</u> 433.9 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>ARTERIOSCLEROTIC CEREBROVASCULAR DISEASE</u> DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 4 HOURS 5 YEARS					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 332x					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)	
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State	
22a. I certify that (I) (this hospital) attended the deceased from <u>JUNE</u> , 19 <u>66</u> , to <u>JULY</u> , 19 <u>68</u> , that (I) (we) last saw the deceased alive on <u>MAY 5</u> , 19 <u>68</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE Norman K. Bohrer			DEGREE ATTENDING PHYS.	MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22c. DATE SIGNED July 12, 1968
22d. PHYSICIAN'S NAME (Type) Norman K. Bohrer, M. D.			22e. ADDRESS 3231 Superior Lane Bowie, Md.		
23a. BURIAL, CREMATION, REMOVAL (Specify) Cremation	23b. DATE 7/12/68	23c. NAME OF CEMETERY OR CREMATORY Ft. Lincoln		23d. LOCATION (City or Town) (County) (State) Colmar Manor P. G. Md.	
24. FUNERAL DIRECTOR Francis Gasch's Sons Hyattsville, Md.			25a. REC'D BY REGISTRAR DATE JUL 15 1968		25b. REGISTRAR'S SIGNATURE Charles Judge

1911

STATE OF TEXAS

COUNTY OF DALLAS

IN SENATE,

January 10, 1911.

REPORT

OF THE

COMMISSIONER OF THE LAND OFFICE

FOR THE YEAR 1910.

BY

JOHN W. HARRIS,

COMMISSIONER.

DAVID W. HARRIS,

PRINTED BY THE

STATE OF TEXAS,

1911.



FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form 10-3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

10400

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10409

1. DECEASED-NAME (Type or Print)		First Debra	Middle Ann	Last Barrett	2a. DATE KNOWN OF DEATH ESTIMATED <input checked="" type="checkbox"/> Month Day Year 7 10 1968		2b. HOUR 9:00 p.m.
3. SEX F	4. RACE W	5. DATE OF BIRTH 20 July 1953		6. AGE (in years last birthday) 14 YRS.	IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.	2c. DATE PRONOUNCED DEAD Month Day Year 7 10 68
7a. BIRTHPLACE (State or foreign country) MASS		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Prince George Md.	
10. CITY OR TOWN OF DEATH Clinton		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Andrews Air Base			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) STUDENT		12b. KIND OF BUSINESS OR INDUSTRY
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Georgia		13b. COUNTY Ft. Benning		13c. CITY OR TOWN YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13d. INSIDE CITY LIMITS? 210 Austin Loop.	
14. FATHER'S NAME First Middle Last FRANCIS XAVIER BARRETT		15. MOTHER'S MAIDEN NAME First Middle Last BARBARA ALICE BARRETT					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO		16b. SOCIAL SECURITY NO. (If yes give war or dates of service) N/A		17. INFORMANT ADDRESS Military Records-AAFB Hospital			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute myelogenous leukemia and over 4 days</u> 2040 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Subarachnoid</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Hemorrhage</u>							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 2043							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? WRGH YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> By WRGH							
ACTUAL SIGNATURE EXAMINER'S NAME (Type)		John K. Kroe, M.D., Riverdale, Md.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		22b. DATE SIGNED 7-11-68	
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE 16 JULY 1968		23c. NAME OF CEMETERY OR CREMATORY ARLINGTON NATIONAL CEMETERY		23d. LOCATION (City or Town) (County) (State) ARLINGTON VA.	
24. FUNERAL DIRECTOR RINALDI FUNERAL HOME 7400 GEORGIA AVE. N.W.		25a. REC'D BY REGISTRAR DATE: JUL 15 1968		25b. REGISTRAR'S SIGNATURE J. Charles Judge			



100

UNITED STATES DEPARTMENT OF JUSTICE
FEDERAL BUREAU OF INVESTIGATION

REPORT OF SPECIAL AGENT IN CHARGE

DATE: May 1955

TO: SAC, NEW YORK

FROM: SAC, NEW YORK

CLINTON

SUBJECT: [Illegible]

RE: [Illegible]

RE: [Illegible]

DATE: May 1955

TO: SAC, NEW YORK

FROM: SAC, NEW YORK

SUBJECT: [Illegible]

RE: [Illegible]

100

UNITED STATES DEPARTMENT OF JUSTICE
FEDERAL BUREAU OF INVESTIGATION

TO: SAC, NEW YORK

FROM: SAC, NEW YORK

CLINTON

DATE: May 1955

TO: SAC, NEW YORK

May 1955

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then, please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
10401 FIRST CERTIFICATE OF DEATH 10410									
1. DECEASED-NAME (Type or print) LORETTA (LOURETTA) BEALL					2a. DATE OF DEATH Month 7 Day 1 Year 68		2b. HOUR 11:30 P M		
3. SEX FEMALE		4. RACE WHITE		5. DATE OF BIRTH AUG. 14 - 1879		6. AGE (In years lost birthday) 88 YRS.		IF UNDER 1 YEAR MONTHS 88 DAYS 88 HOURS 88 MIN.	
7a. BIRTHPLACE (State or foreign country) MARYLAND		7b. CITIZEN OF WHAT COUNTRY? U.S.A		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH PRINCE GEORGE Md.			
10. CITY OR TOWN OF DEATH FORESTVILLE		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) REGENT NURSING		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) RETD - LANSHURGH		12b. KIND OF BUSINESS OR INDUSTRY			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) WASHINGTON STATE		13b. COUNTY WASH. DC		13c. CITY OR TOWN WASH. DC		13d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		13e. STREET AND NUMBER 4237-ALABAMA AVE SE	
14. FATHER'S NAME First SAMUEL J. Middle O Last OWENS			15. MOTHER'S MAIDEN NAME First MARY A. Middle McDONALD Last McDONALD						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown)		16b. SOCIAL SECURITY NO. 578-01-3360		17. INFORMANT MABEL E. BALDWIN Address 5525-DAVIS BLVD SE					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CHRONIC URINARY TRACT INFECTION 2509 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DIABETES MELLITUS 2608 DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 4 MO. 8 YRS.									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (o) Generalized ARTERIO SCLEROSIS									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (H) (this hospital) attended the deceased from 11-28 , 19 67 , to 7-1 , 19 68 , that (H) (we) last saw the deceased alive on 7-1 , 19 68 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (H) (we) (did) (did not) view the body after death.									
22b. SIGNATURE W.B. Sheer M.D.				22c. DATE SIGNED 7-1-68					
22d. PHYSICIAN'S NAME (Type) WALTER B. SHEER				22e. ADDRESS 6400 MARLBORO PIKE S.E. WASH. D.C.					
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE Burial July 5-68		23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Mausoleum		23d. LOCATION (City or Town) (County) (State) Suitland, Maryland			
24. FUNERAL DIRECTOR Simmons Bros		ADDRESS 1661-Good Hope RD SE		25a. REC'D BY REGISTRAR JUL - 5 1968		25b. REGISTRAR'S SIGNATURE Charles Judge			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH										
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										
CERTIFICATE OF DEATH										
1. DECEASED-NAME (Type or print)			First Middle Last			2a. DATE OF DEATH		2b. HOUR		
Jessie			Lorraine			7		Month 16 Day 68 Year 9A. M		
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)		IF UNDER 1 YEAR		
F		W.		2-14-98		70 YRS.		MONTHS DAYS HOURS MIN.		
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH				
MICHIGAN		U.S.A.				PRINCE GEORGES Md.				
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY				
HYATTSVILLE		HYATTSVILLE NURS. HOME		GOVT. SECT.						
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER		
VA.		ARLINGTON		ARLINGTON				860 So. GREENBRIER		
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME							
First Middle Last			First Middle Last							
DANA K. BENNETT			JESSA E. BENNETT							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown)			16b. SOCIAL SECURITY NO.			17. INFORMANT			Address	
NO			578-32-0566			REV. BARCLAY BROWN			1370 LOCUST RD. N.W. WASHINGTON, D.C.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY:										
IMMEDIATE CAUSE (a) Cerebral Thrombosis									24 hrs.	
DUE TO, OR AS A CONSEQUENCE OF (b) Cerebral Arteriosclerosis									8 mo.	
DUE TO, OR AS A CONSEQUENCE OF (c)										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a)										
332x Arteriosclerotic Heart Disease & Atrial Fibrillation										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.)						
		HOUR A.M. Month Day Year P.M. 19								
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION		Street or R.F.D. No.		City or Town County State		
22a. I certify that (I) (this hospital) attended the deceased from 1-13, 1945, to 7-16, 1968, that (I) (we) lost the deceased alive on 7-16, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE		22c. DATE SIGNED								
Louis Ross MD		7-16-68								
22d. PHYSICIAN'S NAME (Type)		22e. ADDRESS								
Louis Ross		1712 Eye St. N.W. Wash. DC. 20006								
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)				
Burial		July 20, 1968		Oak Hill Cemetery		Grand Rapids, Michigan				
24. FUNERAL DIRECTOR		ADDRESS		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE				
J.W. Lee		8434 Georgia Avenue		JUL 19 1968		Charles Judge				
Warner E. Pumphrey, Inc.		Silver Spring, Md.								

Blank form with faint horizontal lines and a vertical line on the right side.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE HEALTH DEPT.

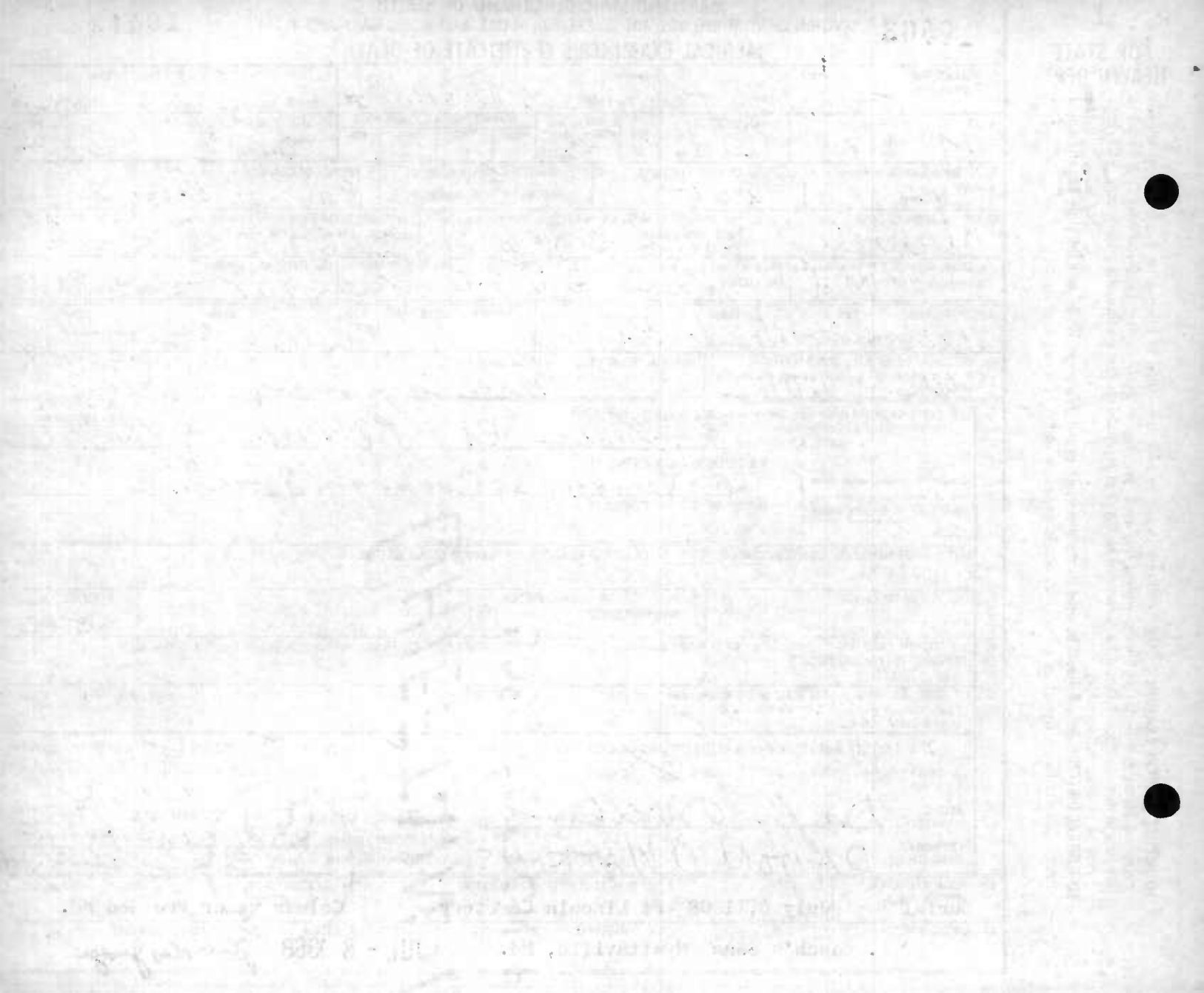
10403

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

10412

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or Print) First Middle Last TRONE THOMPSON BISHOP Sr			2a. DATE KNOWN OF DEATH ESTI- MATED <input type="checkbox"/> Month Day Year July 2 1968			2b. HOUR 12:30 PM																	
3. SEX M		4. RACE W		5. DATE OF BIRTH June 26 1915		6. AGE (In years last birthday) 53 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.		2c. DATE PRONOUNCED DEAD Month Day Year July 2 1968			2d. HOUR 1:05 PM										
7a. BIRTHPLACE (State or foreign country) VA				7b. CITIZEN OF WHAT COUNTRY? USA				8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				9. COUNTY OF DEATH Prince Georges Md											
10. CITY OR TOWN OF DEATH Chesley				11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Prince Georges Gen Bellman				12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Hotel				12b. KIND OF BUSINESS OR INDUSTRY											
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Md				13b. COUNTY Prinns Puerbale				13c. CITY OR TOWN Puerbale				13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 5708-64 Pl									
14. FATHER'S NAME First Middle Last Alexander Hamilton Bishop				15. MOTHER'S MAIDEN NAME First Middle Last Pauline Owens				16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) yes				16b. SOCIAL SECURITY NO. 44-2				17. INFORMANT Mrs Irene Bishop Puerbale				ADDRESS 5708-64 Pl			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>occlusion Rt & Left Coronary arteries</u> DUE TO, OR AS A CONSEQUENCE OF 4109 (b) <u>arteriosclerosis - Coronary Sclerosis</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.														APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) 4201																							
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?								20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>											
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 19				21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)															
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)				21f. LOCATION Street or R.F.D. No. City or Town County State															
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>														22b. DATE SIGNED 7-368 531, 8 Annopolis Rd Beadenshire Md									
ACTUAL SIGNATURE EXAMINER'S NAME (Type) DALTON O WATKINS				M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>															
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial				23b. DATE July 6, 1968				23c. NAME OF CEMETERY OR CREMATORY Ft Lincoln Cemetery				23d. LOCATION (City or Town) (County) (State) Colmar Manor Pro Geo Md.											
24. FUNERAL DIRECTOR F. Gasch's Sons Hyattsville, Md.				ADDRESS				25a. REC'D BY REGISTRAR JUL - 8 1968				25b. REGISTRAR'S SIGNATURE J Charles Judge											



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-100. 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE
HEALTH DEPT.

Items 18&22a Film 404 Maryland State Department of Health
9-24-68 ams DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10413

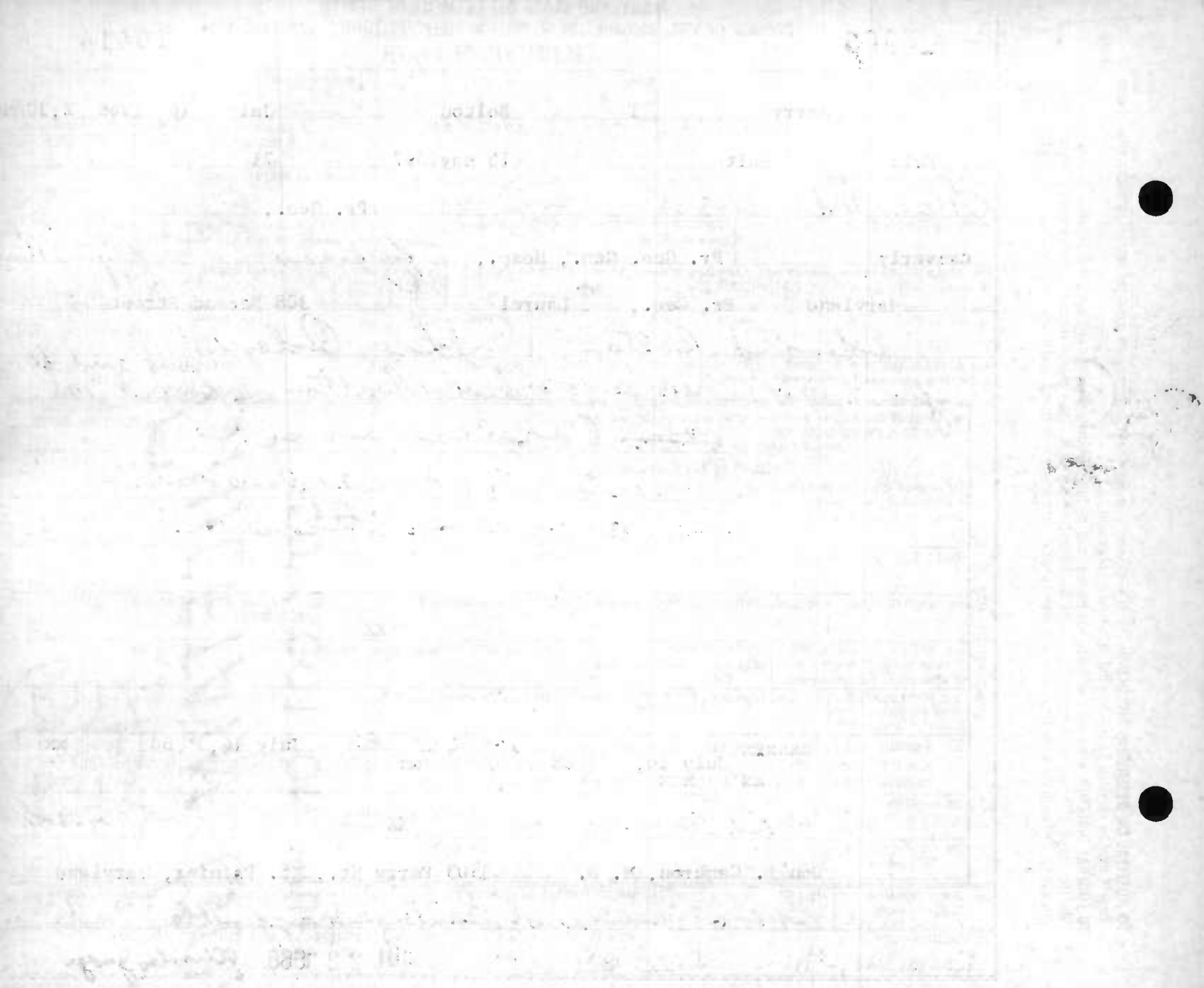
1. DECEASED-NAME (Type or Print) First Middle Last Florence I Blankenship				2a. DATE KNOWN OF ESTI- DEATH MATED <input checked="" type="checkbox"/> 7-13-68 1988 11:06pm			
3. SEX Female	4. RACE White	5. DATE OF BIRTH 2-23-1915	6. AGE (In years last birthday) 53 YRS.	IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (State or foreign country) Canada		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Prince George's	
10. CITY OR TOWN OF DEATH Cheverly		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Prince George Hospital		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Unemployed		12b. KIND OF BUSINESS OR INDUSTRY -	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE District of Columbia				13c. CITY OR TOWN Washington		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME First Middle Last Cecil Mattice				15. MOTHER'S MAIDEN NAME First Middle Last Cecilia ?			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes give war or dates of service) -		16b. SOCIAL SECURITY NO. 224-34-9380		17. INFORMANT ADDRESS Andrew E. Blankenship-son Ontario, Ca.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Intoxication 303.9 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Ethyl alcohol DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 3222							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
23a. ACTUAL SIGNATURE EXAMINER'S NAME (Type) John Kehoe MD		23b. DATE 7-19-1968		23c. NAME OF CEMETERY OR CREMATORY Riverdale Md.		23d. LOCATION (City or Town) (County) (State) Suitland, Maryland	
24. FUNERAL DIRECTOR Lee Funeral Home-300 4th St. NE Wash., D.C.		25a. REC'D BY REGISTRAR JUL 22 1968		25b. REGISTRAR'S SIGNATURE Charles Judge			

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MEDICAL CERTIFICATION

10403		DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201				10414	
CERTIFICATE OF DEATH							
1. DECEASED-NAME (Type or print) First Middle Last Harry T Bolton			2a. DATE OF DEATH Month Day Year July 16 1968			2b. HOUR 2.30AM	
3. SEX Male		4. RACE White		5. DATE OF BIRTH 13 May 1897		6. AGE (In years lost birthday) 71 YRS.	
7a. BIRTHPLACE (State or foreign country) Bethesda Md.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Pr. Geo., Md.	
10. CITY OR TOWN OF DEATH Cheverly		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Pr. Geo. Gen. Hosp.		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) foreman		12b. KIND OF BUSINESS OR INDUSTRY U.S. Dept of Agriculture	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland		13b. COUNTY Pr. Geo.,		13c. CITY OR TOWN Laurel		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME First Middle Last Edward Bolton		15. MOTHER'S MAIDEN NAME First Middle Last Ida Oden		13e. STREET AND NUMBER 308 Second Street			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) yes		16b. SOCIAL SECURITY NO. (If yes give war or dates of service) WW1		17. INFORMANT Leola Bolton		Address 308 2nd St Laurel Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4109 Acute Cardiac arrest DUE TO, OR AS A CONSEQUENCE OF (b) acute myocardial infarction DUE TO, OR AS A CONSEQUENCE OF (c) acute coronary thrombosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) 4201							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that (I) (the hospital) attended the deceased from July 14, 1968 to July 16, 1968 , that (I) (the) last saw the deceased alive on July 16, 1968 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (do not) view the body after death.							
22b. SIGNATURE Don B. Cameron				DEGREE M.D.		22c. DATE SIGNED July 16, 1968	
22d. PHYSICIAN'S NAME (Type) Don B. Cameron, M. D.				22e. ADDRESS 3503 Perry St., Mt. Rainier, Maryland			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 7-18-68		23c. NAME OF CEMETERY OR CREMATORY Emmanuel Cemetery		23d. LOCATION (City or Town) (County) (State) Scaggsville Md.	
24. FUNERAL DIRECTOR Harold Sam Ditt				ADDRESS Laurel, Md.		25a. RECEIVED BY REGISTRAR JUL 22 1968	
				25b. REGISTRAR'S SIGNATURE Charles Judge			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

10406

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

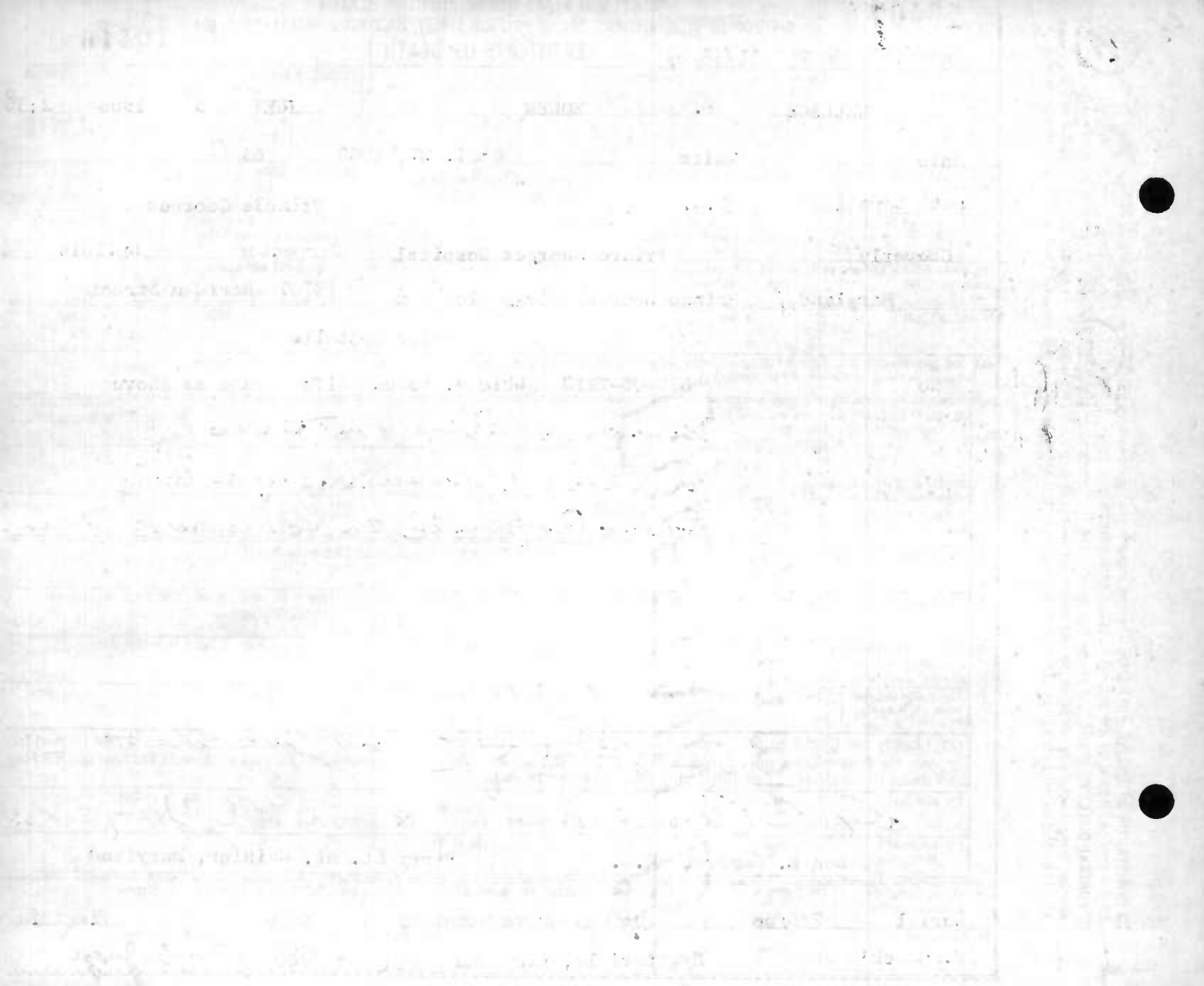
10415

1. DECEASED-NAME (Type or print) Marie M. Bosc			2a. DATE OF DEATH July 14, 1968			2b. HOUR 1:55 P.M.			
3. SEX Female		4. RACE Caucasian		5. DATE OF BIRTH 3/24/1892		6. AGE (In years lost birthday) 76 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN	
7a. BIRTHPLACE (State or foreign country) Italy		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Prince George's Md.			
10. CITY OR TOWN OF DEATH Cheverly		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Prince Geo. Gen'l Hospital		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Housewife		12b. KIND OF BUSINESS OR INDUSTRY At Home			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland		13b. COUNTY Prince George's		13c. CITY OR TOWN Seat Pleasant		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 6470 Addison Rd.	
14. FATHER'S NAME First Middle Last Unknown			15. MOTHER'S MAIDEN NAME First Middle Last Unknown						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16b. SOCIAL SECURITY NO. (If yes give war or dates of service)		17. INFORMANT Hospital Records Address					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac failure with pulmonary edema & congestion. 4409 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (b) Chronic passive congestion of liver with centrilobular necroses & jaundice. DUE TO, OR AS A CONSEQUENCE OF (c) Generalized arteriosclerosis, severe.									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) 4500 Status 2 week post resection of abdominal aortic aneurysm.									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) this hospital attended the deceased from March, 1968 , to July 14, 1968 , that (I) was lost saw the deceased alive on July 14, 1968 , and that in (my) own opinion death occurred on the date and hour and from the causes stated above, (I) was (did) not view the body after death.									
22b. SIGNATURE Wm. A. Holbrook		22c. DATE SIGNED July 15, 1968		22d. PHYSICIAN'S NAME (Type) William A. Holbrook, M. D.		22e. ADDRESS 4500 College Ave., College Park, Md. 20740			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 7/17/68		23c. NAME OF CEMETERY OR CREMATORY Fort Lincoln Cem.		23d. LOCATION (City or Town) (County) (State) Colmar Manor Maryland			
24. FUNERAL DIRECTOR J. Wm. Lees Sons, Co. 300 4th St, Wash. D.C.				25a. REC'D BY REGISTRAR DATE JUL 17 1968		25b. REGISTRAR'S SIGNATURE John H. Judge			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

10407		DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201				10416								
Item #6, Film G402 7/11/68 km								CERTIFICATE OF DEATH						
1. DECEASED-NAME (Type or print)				First		Middle		Last		2a. DATE OF DEATH Month Day Year			2b. HOUR	
WALLACE E. BOWEN										JULY 5 1968			2:30	
3. SEX		4. RACE		5. DATE OF BIRTH			6. AGE (In years lost birthday)		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.			
Male		White		SEPT. 27, 1903			65 6 1/2 YRS.							
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH								
South Carolina		U.S.				Prince Georges Md.								
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)			12b. KIND OF BUSINESS OR INDUSTRY						
Cheverly		Prince Georges Hospital			Carpenter			Building						
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER						
Maryland		Prince George		Riverdale		X		4707 Sheridan Street						
14. FATHER'S NAME				First		Middle		Last		15. MOTHER'S MAIDEN NAME				
										Hester Costello				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, (name and rank) (If yes give war or dates of service)				16b. SOCIAL SECURITY NO.		17. INFORMANT		Address						
No				579-05-7216		Abbie A. Bowen Wife		Same as above						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Massive Hemorrhage 1621 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) ruptured pulmonary artery DUE TO, OR AS A CONSEQUENCE OF (c) bronchogenic carcinoma Trachea PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 1621								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH						
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?							
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)									
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State									
22a. I certify that (I) (this hospital) attended the deceased from Nov 1967 to July 5 1968 that (I) (we) last saw the deceased alive on July 5 1968 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.								22b. SIGNATURE Don B. Cameron M.D.		22c. DATE SIGNED July 2, 1968				
22d. PHYSICIAN'S NAME (Type)		22e. ADDRESS			22f. DEGREE		22g. MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22h. ATTENDING PHYS. <input checked="" type="checkbox"/>					
Don B. Cameron		Perry St. Mt. Rainier, Maryland												
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)								
Burial		7/8/68		Pin Oak Grove Cemetery		Zepp Virginia								
24. FUNERAL DIRECTOR		F. Gasch's Sons		ADDRESS Hyattsville, Maryland		25a. REC'D BY REGISTRAR JUL - 8 1968		25b. REGISTRAR'S SIGNATURE J Charles Judge						



FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil. Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

Item 18 Film 404 8-28 MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										10417		
10408 MEDICAL EXAMINER'S CERTIFICATE OF DEATH												
1. DECEASED-NAME (Type or Print) First Middle Last Mildred A Bowles					2a. DATE KNOWN OF DEATH Month Day Year July 3 1968			2b. HOUR M 11:00				
3. SEX F		4. RACE W		5. DATE OF BIRTH April 11-1910		6. AGE (in years last birthday) 58 YRS.		IF UNDER 1 YEAR MONTHS DAYS 58		IF UNDER 24 HRS. HOURS MIN. 58		
7a. BIRTHPLACE (State or foreign country) West Virginia			7b. CITIZEN OF WHAT COUNTRY? U.S.			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH PRINCE GEORGE Md.			
10. CITY OR TOWN OF DEATH CHEVERLY				11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) PRINCE GEORGE GENERAL				12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) HOUSEWIFE		12b. KIND OF BUSINESS OR INDUSTRY HOME		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE MARYLAND					13b. COUNTY PRINCE GEORGE		13c. CITY OR TOWN BLADENSBURG		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 4307-57th Ave.	
14. FATHER'S NAME First Middle Last CLIFTON E. SULABAUGH					15. MOTHER'S MAIDEN NAME First Middle Last CARRIE RUPPENTHAL							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO					16b. SOCIAL SECURITY NO. 578-01-5588		17. INFORMANT ADDRESS Frances Michael sister Williamsport, Md.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 514X DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Pulmonary edema, Severe DUE TO, OR AS A CONSEQUENCE OF (c) (Etiology undetermined)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 522X												
19a. DATE OF OPERATION					19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?					20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>			21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.)						
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)			21f. LOCATION Street or R.F.D. No. City or Town County State						
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>												
ACTUAL SIGNATURE Dayton Watkins			EXAMINER'S NAME (Type) DAYTON WATKINS			CHIEF MEDICAL EXAMINER <input type="checkbox"/> 7-5-61			22b. DATE SIGNED 5318 Annapolis			
						DEPUTY MEDICAL EXAMINER <input type="checkbox"/>			ADDRESS (Street, city, town, or county) Bladensburg			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial			23b. DATE 7/8/68		23c. NAME OF CEMETERY OR CREMATORY Ft. Lincoln Cemetery			23d. LOCATION (City or Town) (County) (State) Colmar Manor Maryland				
24. FUNERAL DIRECTOR ADDRESS F. Gasch's Sons Hyattsville, Maryland					25a. REC'D BY REGISTRAR JUL - 8 1968		25b. REGISTRAR'S SIGNATURE f Charles Judge					

297

Revised

Revised

1952

1952-1953

Annual Report of the

Department of the Interior

for the year ending

December 31, 1952

Washington, D.C.

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FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Form DM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or Print)		First	Middle	Lost	2a. DATE KNOWN OF DEATH		<input type="checkbox"/> Month	<input type="checkbox"/> Day	<input type="checkbox"/> Year	2b. HOUR	
William J Brauer					ESTIMATED <input checked="" type="checkbox"/> 7 13 19 68					4:45 PM	
3. SEX	4. RACE	5. DATE OF BIRTH		6. AGE (in years last birthday)	IF UNDER 1 YEAR		IF UNDER 24 HRS		2c. DATE PRONOUNCED DEAD		
M	W	29 July 1914		53 YRS.	MONTHS DAYS		HOURS MIN.		Month 7 Day 13 Year 68		
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH					
Balto. City		USA				Prince George Md.					
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (if not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b. KIND OF BUSINESS OR INDUSTRY					
Cheverly		Prince George		C.&P. Telephone Co.							
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER			
Md		BALTO		Reisterstown				118 2nd Ave.,			
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME									
John Brauer		Theresa Plock									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS							
No		212-05-0922		Mrs. Eugenia Brauer Reisterstown, Md.							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Heart failure DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. 4129 (b) Arteriosclerotic heart disease DUE TO, OR AS A CONSEQUENCE OF (c) unknown APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Minutes											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 4200											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)							
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No. City or Town County State							
22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE		CHIEF MEDICAL EXAMINER <input type="checkbox"/>				22b. DATE SIGNED					
EXAMINER'S NAME (Type)		John Kehoe, M.D., Riverdale				7-14-68					
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)					
Burial		July 17, 68		Evergreen Memorial		Finksburg, Md.					
24. FUNERAL DIRECTOR ADDRESS				25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE					
J. F. Eline & Sons Reisterstown, Md.				JUL 16 1968		J. Charles Judge					

Name of Deceased		Age		Sex		Race		Date of Death		Place of Death	
John Doe		45		Male		White		July 15, 1958		New York City	
Occupation		Cause of Death		Manner of Death		Medical History		Previous Illnesses		Post-mortem Examination	
Teacher		Heart Disease		Natural		Hypertension		Coronary Artery Disease		No significant findings	
Date of Birth		Date of Admission		Date of Discharge		Date of Death		Date of Autopsy		Date of Report	
Jan 1, 1913		Jul 10, 1958		Jul 12, 1958		Jul 15, 1958		Jul 16, 1958		Jul 17, 1958	
Signature of Examiner		Signature of Physician		Signature of Coroner		Signature of Medical Examiner		Signature of Pathologist		Signature of Forensic Scientist	
[Signature]		[Signature]		[Signature]		[Signature]		[Signature]		[Signature]	
Date of Report		Date of Report		Date of Report		Date of Report		Date of Report		Date of Report	
Jul 18, 1958		Jul 18, 1958		Jul 18, 1958		Jul 18, 1958		Jul 18, 1958		Jul 18, 1958	



100

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

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FOR STATE HEALTH DEPT.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or Print) First Middle Last Annie E Brown						2a. DATE KNOWN <input checked="" type="checkbox"/> Month Day Year OF ESTI- DEATH MATED <input type="checkbox"/> 7-14-68 192: 10am		
3. SEX Female	4. RACE Negro	5. DATE OF BIRTH 4 March 1889	6. AGE (In years last birthday) 79 YRS.	IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS HOURS MIN.	2c. DATE PRONOUNCED DEAD Month Day Year 7 14 68 192: 10am		
7a. BIRTHPLACE (State or foreign country) Maryland		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Prince George's Md.		
10. CITY OR TOWN OF DEATH Cheverly			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Prince George Hospital			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland			13b. COUNTY Prince George Seat Pleasant			13c. CITY OR TOWN YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 6407 Kolb Street
14. FATHER'S NAME First Middle Last unknown			15. MOTHER'S MAIDEN NAME First Middle Last Mary Edglen					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		(If yes give war or dates of service)		16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Heart failure 4129 DUE TO, OR AS A CONSEQUENCE OF Arteriosclerotic heart disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. unknown (b) _____ DUE TO, OR AS A CONSEQUENCE OF _____ (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH								
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) 4200								
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No. City or Town County State				
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>								
ACTUAL SIGNATURE John Kehoe		EXAMINER'S NAME (Type) John Kehoe MD		M.D. Riverdale, Md.		22b. DATE SIGNED 7-15-68		
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 7/19/68		23c. NAME OF CEMETERY OR CREMATORY Woodlawn Cemetery		23d. LOCATION (City or Town) (County) (State) Washington, D.C.		
24. FUNERAL DIRECTOR John T. Stewart				25a. REC'D BY REGISTRAR JUL 16 1968		25b. REGISTRAR'S SIGNATURE J. Charles J...		
Stewart Funeral Home-4001 Benning Rd., N.W.								

NOT FOR
HEAVY DUTY

1000

WETLAND EXAMINER'S CERTIFICATE OF REVIEW

Project Name	1000
Location	1000
Project Number	1000
Project Description	1000
Project Status	1000
Project Manager	1000
Project Engineer	1000
Project Designer	1000
Project Checker	1000
Project Approver	1000
Project Reviewer	1000
Project Auditor	1000
Project Inspector	1000
Project Supervisor	1000
Project Coordinator	1000
Project Assistant	1000
Project Secretary	1000
Project Clerk	1000
Project Receptionist	1000
Project Mail Room	1000
Project Storage Room	1000
Project Office	1000
Project Warehouse	1000
Project Shop	1000
Project Garage	1000
Project Yard	1000
Project Grounds	1000
Project Site	1000
Project Area	1000
Project Zone	1000
Project Sector	1000
Project District	1000
Project Region	1000
Project Division	1000
Project Department	1000
Project Bureau	1000
Project Agency	1000
Project Commission	1000
Project Authority	1000
Project Office	1000
Project Department	1000
Project Division	1000
Project Region	1000
Project District	1000
Project Sector	1000
Project Zone	1000
Project Area	1000
Project Site	1000
Project Grounds	1000
Project Yard	1000
Project Garage	1000
Project Shop	1000
Project Warehouse	1000
Project Office	1000
Project Bureau	1000
Project Agency	1000
Project Commission	1000
Project Authority	1000

CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or print)		First VICTORIA		Middle BROWN		Last BROWN		2a. DATE OF DEATH Month 7 Day 16 Year 68		2b. HOUR 9:29 PM	
3. SEX F		4. RACE WHITE		5. DATE OF BIRTH 4/10/79		6. AGE (In years lost birthday) 89 YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (State or foreign country) Wash. DC		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH PRINCE GEORGES Md					
10. CITY OR TOWN OF DEATH FORESTVILLE		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) REGENT NURSING HOME		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Nurse		12b. KIND OF BUSINESS OR INDUSTRY Name					
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Md		13b. COUNTY P.G.		13c. CITY OR TOWN Laurel		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 927 7th Street			
14. FATHER'S NAME First Joseph		Middle Arth		Last Brown		15. MOTHER'S MAIDEN NAME First Henrietta		Middle Scala		Last	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown no		16b. SOCIAL SECURITY NO.		17. INFORMANT Richard R. Anderson		Address 927 7th St Laurel Md.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Coronary thrombosis</u> 4109 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. <u>4201</u> (b) <u>Arteriosclerotic Heart disease</u> DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 8 HRS. YRS											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <u>Cerebral thrombosis - old</u>											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No.		City or Town		County		State	
22a. I certify that (H) (this hospital) attended the deceased from <u>3-20</u> , 19 <u>68</u> , to <u>7-16</u> , 19 <u>68</u> , that (H) (we) last saw the deceased alive on <u>7-16</u> , 19 <u>68</u> , and that in (M) (our) opinion death occurred on the date and hour and from the causes stated above, (H) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <u>W.B. Sheer</u>		M.D. DEGREE		ATTENDING PHYS. <input type="checkbox"/>		MED. DIRECTOR <input type="checkbox"/>		STAFF PHYS. <input checked="" type="checkbox"/>		22c. DATE SIGNED 7-16-68	
22d. PHYSICIAN'S NAME (Type) WALTER B. SHEER		22e. ADDRESS 6400 MARLBORO PIKE S.E. WASH. D.C.									
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 7-19-68		23c. NAME OF CEMETERY OR CREMATORY Washington Natl		23d. LOCATION (City or Town) Suitland		(County) Md.		(State)	
24. FUNERAL DIRECTOR <u>Anderson Funeral Home</u>		ADDRESS Laurel Md		25a. REC'D BY REGISTRAR DATE JUL 22 1968		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>					

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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10412				DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201				10421				
1. DECEASED-NAME (Type or print)				First	Middle	Last	2a. DATE OF DEATH Month Day Year				2b. HOUR	
William O. Brown							July 14, 1968				2:30 M	
3. SEX		4. RACE		5. DATE OF BIRTH			6. AGE (In years last birthday)		IF UNDER 1 YEAR		IF UNDER 24 HRS.	
Male		Caucasian		Aug. 29, 1905			62 YRS.		MONTHS DAYS		HOURS MIN.	
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. COUNTY OF DEATH						
Laurel Md		USA				Prince George's Md.						
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)				12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY				
Cheverly		Prince Geor.Gen'l Hospital				latter operator		Hany Yard				
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER				
Maryland		Prince George's		Laurel				Cherrylane Road				
14. FATHER'S NAME		First	Middle	Last	15. MOTHER'S MAIDEN NAME		First	Middle	Last			
Walter O. Brown					Sarah Leishear							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) (If yes give war or dates of service)		16b. SOCIAL SECURITY NO.		17. INFORMANT		Address						
no				Velma Grimes		Laurel Md.						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Thrombosis</u> 4339 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Cerebral atherosclerosis</u> DUE TO, OR AS A CONSEQUENCE OF (c)										28 days year		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (o)												
332X												
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State							
22a. I certify that he (this hospital) attended the deceased from <u>July 13, 1968</u> , to <u>July 14, 1968</u> , that he (we) last saw the deceased alive on <u>July 14, 1968</u> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above, he (we) (did) (did not) view the body after death.												
22b. SIGNATURE				DEGREE		ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22c. DATE SIGNED				
Donald C. Edgren								July 15, 1968				
22d. PHYSICIAN'S NAME (Type)				22e. ADDRESS								
Donald Edgren, M. D.				Prince Geo. Plaza, Hyattsville, Md.		20783						
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)						
Burial		7-17-68		Amy Hill Cem.		Laurel Md						
24. FUNERAL DIRECTOR				ADDRESS		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE				
De Witt Darnedean				Laurel Md		JUL 22 1968		J Charles Judge				

1118

Date

Enclosure

Aug. 13, 1905

Postage

Chas. Wood

Received

Edison Electric Co.

Edison Electric Co.

Edison Electric Co. 1000

Edison Electric Co. 1000

Edison Electric Co. 1000

Edison Electric Co. 1000

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Edison Electric Co. 1000

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MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
CERTIFICATE OF DEATH									
1. DECEASED-NAME (Type or print)			First Middle Last			2a. DATE OF DEATH		2b. HOUR	
Bruce Louis Buck						Month Day Year July 13, 1968		12 A.M.	
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)		7. IF UNDER 1 YEAR	
Male		White		Oct. 1, 1875		92 YRS.		MONTHS DAYS HOURS MIN	
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH			
Penna.		U. S. A.				Prince Georges Md.			
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY	
Upper Marlboro			Old Crain Highway			Tobacco Farming		Own Farm	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE			13b. COUNTY			13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
Md.			Pr. Geo's			Upper Marlboro		Old Crain Highway	
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME						
First Middle Last Daniel R. Buck			First Middle Last Susan -- Robison						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown)			16b. SOCIAL SECURITY NO.			17. INFORMANT Address			
No			217-36-658			Russell Buck - Upper Marlboro, Md.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Arteriosclerosis</u> 437.9 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 10 yrs									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) 334x									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)				
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)			21f. LOCATION Street or R.F.D. No. City or Town County State				
22a. I certify that (I) (this hospital) attended the deceased from <u>Jan 1946</u> , to <u>July 13, 1968</u> , that (I) (we) last saw the deceased alive on <u>8 May 1968</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <u>Robert B. Sasscer</u>					DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED 7/13/68		
22d. PHYSICIAN'S NAME (Type) Robert B. Sasscer, M. D.					22e. ADDRESS Upper Marlboro, Md. 20870:				
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)			
Burial		7/16/68		Trinity Cemetery		Upper Marlboro P.G. Md.			
24. FUNERAL DIRECTOR ADDRESS					25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE		
Ritchie Bros. Upper Marlboro, Md.					DATE JUL 24 1968		<u>Charles Judge</u>		

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR 15 (1)
30M REV. 7/68

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										
CERTIFICATE OF DEATH										
1. DECEASED-NAME (Type or print)			First Middle Last			2a. DATE OF DEATH Month Day Year		2b. HOUR		
Dorrance B Burdick						27 July 1968		11.55 PM		
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)		IF UNDER 1 YEAR MONTHS DAYS		
Male		White		10 June 1917		49 51 YRS.				
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. COUNTY OF DEATH		Md.		
Wash, D.C.		U S A				Pr. Geo.				
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY		
Cheverly			Pr. Geo., Gen., Hosp.			N.S.A.		U.S. Govt.		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE			13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER	
Maryland			Pr. Geo.		College Park				4816 Erie Street	
14. FATHER'S NAME First Middle Last			15. MOTHER'S MAIDEN NAME First Middle Last							
Bernie Burdick			Jeanette Brown							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown			16b. SOCIAL SECURITY NO.		17. INFORMANT Address					
Yes <input checked="" type="checkbox"/> (If yes give year or dates of service)			WWII 578166190		Thomas Dunn College Park, Md.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Pulmonary edema</u> <u>4109</u> DUE TO, OR AS A CONSEQUENCE OF <u>Coronary Thrombosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Coronary Thrombosis</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Arteriosclerotic Heart Disease</u> <u>15 yrs</u>								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>2-3 hrs.</u> <u>24 hrs.</u> <u>15 yrs</u>		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <u>4201 Corbetta acute cholecystitis</u>										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)						
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No.		City or Town		County State		
22a. I certify that (I) (this hospital) attended the deceased from <u>June 19 55</u> to <u>7/27 1968</u> , that (I) (we) last saw the deceased alive on <u>7/27 1968</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE <u>Norman D. Comeau</u>					22c. DATE SIGNED <u>7/28/68</u>		22d. PHYSICIAN'S NAME (Type) <u>Norman D. Comeau</u>			
					22e. ADDRESS <u>Mt Rainier</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)				
Burial		7/31/1968		Ft Lincoln Cemetery		Colmar Manor, Md.				
24. FUNERAL DIRECTOR ADDRESS <u>Nalley Funeral Home Mt. Rainier, Md.</u>					25a. REC'D BY REGISTRAR DATE <u>JUL 31 1968</u>		25b. REGISTRAR'S SIGNATURE <u>John Charles Judge</u>			

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FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 MEDICAL EXAMINER'S CERTIFICATE OF DEATH									
1. DECEASED-NAME (Type or Print) Edward Leo Burns						2a. DATE KNOWN OF DEATH MATED <input type="checkbox"/> Month <input type="checkbox"/> Day <input type="checkbox"/> Year 7-20-68		2b. HOUR 10:16pm	
3. SEX Male	4. RACE White	5. DATE OF BIRTH	6. AGE (In years last birthday) 50? YRS.	IF UNDER 1 YEAR MONTHS <input type="checkbox"/> DAYS <input type="checkbox"/>	IF UNDER 24 HRS. HOURS <input type="checkbox"/> MIN <input type="checkbox"/>	2c. DATE PRONOUNCED DEAD Month 7 Day 20 Year 68		2d. HOUR 10:32pm	
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Prince George's Md.			
10. CITY OR TOWN OF DEATH Cheverly		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Prince George Hospital				12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission), STATE Florida		13b. COUNTY St. Petersburg		13c. CITY OR TOWN St. Petersburg		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 1743 3rd. Avenue	
14. FATHER'S NAME First Middle Last			15. MOTHER'S MAIDEN NAME First Middle Last						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16b. SOCIAL SECURITY NO.			17. INFORMANT ADDRESS			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Laceration of brain 814.7 DUE TO, OR AS A CONSEQUENCE OF Trauma - struck by car Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost: (b) _____ DUE TO, OR AS A CONSEQUENCE OF _____ (c) _____									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) 8124									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY Month, Day, Year HOUR A.M. 10:15pm 7-20-19 68		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) Pedestrian struck by car.					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input checked="" type="checkbox"/> NOT WHILE AT WORK		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) Rt. 5 and Rt. 301,		21f. LOCATION Street or R.F.D. No. City or Town County State Prince George County, Maryland					
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>									
ACTUAL SIGNATURE John Kehoe MD		EXAMINER'S NAME (Type) John Kehoe MD		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		22b. DATE SIGNED 7-21-68			
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE 8-1-68		23c. NAME OF CEMETERY OR CREMATORY Anast. Del. of Md. Univ of Md. Baltimore, Md.		23d. LOCATION (City or Town) (County) (State) Baltimore, Md.			
24. FUNERAL DIRECTOR CHAMBERS				ADDRESS		25a. REC'D BY REGISTRAR DATE AUG 5 1968		25b. REGISTRAR'S SIGNATURE J. Charles Judge	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

10416		DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201		10425	
Item 6 film G 402 7/24/68 11w		CERTIFICATE OF DEATH			
1. DECEASED-NAME (Type or print) James Butler			2a. DATE OF DEATH July 15, 1968		2b. HOUR 10:55 P
3. SEX Male	4. RACE Negro	5. DATE OF BIRTH 6/12/1902		6. AGE (In years last birthday) 65 66 YRS.	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.
7a. BIRTHPLACE (State or foreign country) Maryland	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH Prince George's Md.		
10. CITY OR TOWN OF DEATH Cheverly	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Prince Geo. Gen'l Hospital	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Retired - Gov't.		12b. KIND OF BUSINESS OR INDUSTRY —	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland	13b. COUNTY Prince George's	13c. CITY OR TOWN Fairmont Hgts.	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	13e. STREET AND NUMBER 721 59th Avenue	
14. FATHER'S NAME First Middle Last Summie M. Butler		15. MOTHER'S MAIDEN NAME First Middle Last Georgianna M. Butler			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) (If yes give year or dates of service) No None		16b. SOCIAL SECURITY NO. None		17. INFORMANT Address Thelma Butler Same as 13E	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bilateral Bronchopneumonia. 1899 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Cancer of the Urethra with widespread metastasis. DUE TO, OR AS A CONSEQUENCE OF (c) Emaciation.					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) 1817					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)	
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State	
22a. I certify that (I) (this hospital) attended the deceased from July 15, 1968 , to July 15, 1968 , that (I) (we) last saw the deceased alive on July 15, 1968 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE O. Sahakyan		DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED July 16, 1968	
22d. PHYSICIAN'S NAME (Type) Ohannes Sahakyan, M. D.		22e. ADDRESS 6001 Landover Rd., Cheverly, Md. 20785			
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE 7-19-68		23c. NAME OF CEMETERY OR CREMATORY Mt Olivet	
23d. LOCATION (City or Town) (County) (State) Washington D C					
24. FUNERAL DIRECTOR 145 Washington St Sm 4925 Deane		ADDRESS		25a. REC'D BY REGISTRAR JUL 22 1968	
				25b. REGISTRAR'S SIGNATURE J Charles Judge	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then, please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR 113 (4)
30M REV. 1/68

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
CERTIFICATE OF DEATH									
1. DECEASED-NAME (Type or print) Rita			First Middle Last M. Butterworth			2a. DATE OF DEATH Month Day Year 7 15 68		2b. HOUR 9:08 P M	
3. SEX F		4. RACE W		5. DATE OF BIRTH 5-19-05		6. AGE (In years last birthday) 63 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN	
7a. BIRTHPLACE (State or foreign country) Australia		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Prince George's Md.			
10. CITY OR TOWN OF DEATH Forestville		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Regent Nursing Home		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) housewife		12b. KIND OF BUSINESS OR INDUSTRY Home			
13a. USUAL RESIDENCE (Where deceased admission) STATE Md.		13b. COUNTY PG		13c. CITY OR TOWN Hillcrest Heights		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 2708 Gaither Street	
14. FATHER'S NAME First Middle Last ? Maasdyk			15. MOTHER'S MAIDEN NAME First Middle Last Nancy Dowling						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, name and rank) (If yes give war or dates of service) NO		16b. SOCIAL SECURITY NO. Unknown		17. INFORMANT (Husband) Horace Butterworth,		Address Same as #13			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH CAUSED BY: IMMEDIATE CAUSE (a) AdenoCA right breast - metastasis 174X DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO, OR AS A CONSEQUENCE OF (c)								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 5 yr	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) 170X fracture left femur									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from 11/15, 1950, to 7/15, 1968, that (I) (we) last saw the deceased alive on 7/14/68, 19, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE Leo H. McGowan M.D.				DEGREE M.D.		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED 7/15/68	
22d. PHYSICIAN'S NAME (Type) LEO H. MUGOWAN, M.D.				22e. ADDRESS 2711 GAITHER ST. Hillcrest Heights, Md.					
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE 7-17-68		23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery		23d. LOCATION (City or Town) (County) (State) Suitland, Maryland			
24. FUNERAL DIRECTOR Wilhelm Funeral Home 4308 Suitland Rd. SE, Suitland, Maryland						25a. REC'D BY REGISTRAR DATE JUL 19 1968		25b. REGISTRAR'S SIGNATURE Charles Judge	

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FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Form PW3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										
MEDICAL EXAMINER'S CERTIFICATE OF DEATH										
1. DECEASED-NAME (Type or Print)			First Middle Last			2a. DATE KNOWN OF ESTI- DEATH MATED <input checked="" type="checkbox"/> 7- 15-68 192:		2b. HOUR 00am		
James Robert Canter										
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (In years last birthday)	IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN		2c. DATE PRONOUNCED DEAD Month Day Year		
Male	White	30 July 1918	49 YRS.					7 15 68 19 30am M		
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH				
Maryland		U. S. A.				Prince George's Md.				
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY		
Cheverly			Prince George Hospital			Tobacco Farming		Tenant		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE			13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER	
Maryland			Prince George's		Upper Marlboro		No		No Fixed Address	
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME							
First Middle Last			First Middle Last							
Joseph -- Canter			Cora E. Smith							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> or unknown)			16b. SOCIAL SECURITY NO. (If yes give war or dates of service)			17. INFORMANT				
						2200 Ritchie Rd., Forestville, Md. 20028				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Heart failure</u> DUE TO, OR AS A CONSEQUENCE OF <u>Arteriosclerotic heart disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) _____ DUE TO, OR AS A CONSEQUENCE OF _____ (c) _____									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH minutes unknown	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <u>4200</u>										
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?			20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>			21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No. City or Town County State						
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>										
ACTUAL SIGNATURE			CHIEF MEDICAL EXAMINER <input type="checkbox"/>			22b. DATE SIGNED				
EXAMINER'S NAME (Type) John Kehoe MD Riverdale, Md.			ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			7-16-68				
			DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			ADDRESS (Street, city, town, or county)				
23a. BURIAL, CREMATION, REMOVAL (Specify)			23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)			
Burial			7/22/68		Mt. Carmel Cemetery		Upper Marlboro, P.G. Md.			
24. FUNERAL DIRECTOR					ADDRESS		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	
Ritchie Bros. Upper Marlboro, Md.							DATE JUL 24 1968		J Charles Judge	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH										
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										
CERTIFICATE OF DEATH										
1. DECEASED-NAME (Type or print) First Middle Last Charles A. Carl					2a. DATE OF DEATH Month Day Year July 27, 1968			2b. HOUR 2:45A M		
3. SEX Male		4. RACE White		5. DATE OF BIRTH 11/9/92		6. AGE (In years last birthday) 75 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.		
7a. BIRTHPLACE (State or foreign country) Pa.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Prince George's Md.				
10. CITY OR TOWN OF DEATH Cheverly			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Prince George's Gen. Hosp.			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Forman		12b. KIND OF BUSINESS OR INDUSTRY Gas Co.		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland			13b. COUNTY Prince Geo.		13c. CITY OR TOWN Brentwood		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 3506 Taylor Street	
14. FATHER'S NAME First Middle Last August Carl			15. MOTHER'S MAIDEN NAME First Middle Last Matelda Hagedors							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes (no or unknown) <input checked="" type="checkbox"/> None		16b. SOCIAL SECURITY NO. 208095647		17. INFORMANT Address Goldie Carl (Wife) 3506 Taylor St.						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CONGESTIVE HEART FAILURE 342X DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) BIL PNEUMONIA DUE TO, OR AS A CONSEQUENCE OF (c) PARKINSON'S DISEASE									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 4 days 1 week 16 YEARS	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 350X										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from 1950 , to July 27, 1968 , that (I) (we) lost the deceased alive on JULY 26 1968 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE Benjamin S. Miller M.D.					ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED July 27, 1968			
22d. PHYSICIAN'S NAME (Type) Benjamin S. Miller, M.D.					22e. ADDRESS 3824 34th St., Mt. Rainier, Md.					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 7/30/1968		23c. NAME OF CEMETERY OR CREMATORY Mt. Prospect Cemetery		23d. LOCATION (City or Town) (County) (State) Hickory, Pa.				
24. FUNERAL DIRECTOR ADDRESS Valley Funeral Home Mt. Rainier, Md.					25a. REC'D BY REGISTRAR JUL 30 1968		25b. REGISTRAR'S SIGNATURE Charles J. J...			

CLARK COUNTY OF MICHIGAN

July 27, 1903

Carl

A.

William

To

William

John

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Prince George's

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CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or print) Otho V Carpenter			2a. DATE OF DEATH Month July Day 17 Year 1968			2b. HOUR 12, 30 AM					
3. SEX Male		4. RACE Negro		5. DATE OF BIRTH 11 June 1888		6. AGE (In years lost birthday) 80 YRS.		IF UNDER 1 YEAR MONTHS DAYS 		IF UNDER 24 HRS. HOURS MIN. 	
7a. BIRTHPLACE (State or foreign country) N. C.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. COUNTY OF DEATH Pr. Geo., Md.					
10. CITY OR TOWN OF DEATH Cheverly			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Pr. Geo. Gen., Hosp.			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Moulder			12b. KIND OF BUSINESS OR INDUSTRY Retired		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland			13b. COUNTY P.G.		13c. CITY OR TOWN Wash., D.C.		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 5325 Nye St.,		
14. FATHER'S NAME First Frank Middle Carpenter Last 			15. MOTHER'S MAIDEN NAME First Unknown Middle Last 								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) (If yes give war or dates of service)			16b. SOCIAL SECURITY NO.		17. INFORMANT Address Catherleen Mayhew-828 20th Street, N. E						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Thrombosis 4339 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO, OR AS A CONSEQUENCE OF (c) 										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 332X											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)						
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State						
22a. I certify that (x) (this hospital) attended the deceased from June 29, 1968 , to July 17, 1968 , that (x) (we) lost saw the deceased alive on July 17, 1968 , and that in (x) (our) opinion death occurred on the date and hour and from the causes stated above (x) (we) (did) (not) view the body after death.											
22b. SIGNATURE Donald C. Edgren DEGREE ATTENDING <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>					22c. DATE SIGNED July 17, 1968						
22d. PHYSICIAN'S NAME (Type) Donald Edgren, M. D.					22e. ADDRESS Prince George's General Hospital, Cheverly						
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 7-21-68		23c. NAME OF CEMETERY OR CREMATORY Church Semetery			23d. LOCATION (City or Town) (County) (State) Wakeforest North Carolina Maryland				
24. FUNERAL DIRECTOR John T. Rhines Co. Washington, D. C.					25a. REC'D BY REGISTRAR DATE JUL 22 1968		25b. REGISTRAR'S SIGNATURE f Charles Judge				

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.
Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then, please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

STATE OF TEXAS
COUNTY OF DALLAS

Know all men by these presents, that _____

of the County of _____ State of _____

do hereby certify that _____

is the true and correct copy of _____

as the same appears from the _____

records of _____

and that the same is a true and correct copy of _____

Witness my hand and seal this _____ day of _____

1903

Notary Public in and for the State of Texas

My Comm. Expires _____

Subscribed and sworn to before me this _____ day of _____

1903

Notary Public in and for the State of Texas

My Comm. Expires _____

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
MEDICAL EXAMINER'S CERTIFICATE OF DEATH											
1. DECEASED-NAME (Type or Print) First Middle Last George Samuel Carrington					2a. DATE KNOWN OF ESTI-DEATH MATED <input checked="" type="checkbox"/> 7-18-68 193:22am M		2b. HOUR				
3. SEX Male	4. RACE White	5. DATE OF BIRTH 12-23-1928	6. AGE (In years last birthday) 39 YRS.	IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN	2c. DATE PRONOUNCED DEAD Month Day Year 7 18 68		2d. HOUR 4:26am			
7a. BIRTHPLACE (State or foreign country) Virginia		7b. CITIZEN OF WHAT COUNTRY? U. S		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Prince George's Md.					
10. CITY OR TOWN OF DEATH Cheverly			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Prince George Hospital			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Truck Driver		12b. KIND OF BUSINESS OR INDUSTRY Preston Lines			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before death) admission) STATE Virginia			13b. COUNTY Chesterfield		13c. CITY OR TOWN Richmond		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER 4141 Norbeth Avenue		
14. FATHER'S NAME First Middle Last George S. Carrington				15. MOTHER'S MAIDEN NAME First Middle Last Florence Thomas							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) yes (If yes give war or dates of service) Korean				16b. SOCIAL SECURITY NO.		17. INFORMANT Irene Miller Carrington				ADDRESS Richmond Va. 4141 Narbeth Ave	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) LACERATION OF BRAIN 8150 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) TRAUMA DUE TO, OR AS A CONSEQUENCE OF (c) AUTO ACCIDENT								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH MIN			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 2230											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY Month, Day, Year HOUR A.M. 3:20am 7-18-19 68		21c. HOW INJURY OCCURRED Struck pillar of overpass. Driver of truck which went out of control and						
21d. INJURY OCCURRED WHILE AT WORK <input checked="" type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) Rt. 50 and Ardmore Ardwick Road, Prince George County, Maryland			21f. LOCATION Street or R.F.D. No. City or Town County State						
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE John Kehoe		EXAMINER'S NAME (Type) John Kehoe MD		M.D. Riverdale, Md.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		22b. DATE SIGNED 7-19-68			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 7/21/68		23c. NAME OF CEMETERY OR CREMATORY Wards Chapel		23d. LOCATION (City or Town) (County) (State) Nottoway County Virginia					
24. FUNERAL DIRECTOR Joseph W. Bliley Co				ADDRESS 300 E. Marshall St. Richmond, Va.		25a. REC'D BY REGISTRAR JUL 22 1968		25b. REGISTRAR'S SIGNATURE J Charles Judge			

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FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

10422

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10431

1. DECEASED-NAME (Type or Print) First Middle Last Herbert Hoover Chandler			2a. DATE KNOWN OF ESTI-DEATH MATED <input checked="" type="checkbox"/> 7-13-68 199:17pm M		2b. HOUR
3. SEX Male	4. RACE White	5. DATE OF BIRTH 8-13-1932	6. AGE (In years last birthday) 35 YRS.	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN	2c. DATE PRONOUNCED DEAD Month Day Year 7 13 68 199:50pm M
7a. BIRTHPLACE (State or foreign country) VIRGINIA		7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Prince George's Md.
10. CITY OR TOWN OF DEATH Bladensburg		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) 4275 58th. Avenue		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) MAINT. MAN	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland		13b. COUNTY Prince George's		13c. CITY OR TOWN Bladensburg	
14. FATHER'S NAME First Middle Last Elisha Chandler		15. MOTHER'S MAIDEN NAME First Middle Last Elvira Cutshaw		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) YES		16b. SOCIAL SECURITY NO. UNKNOWN		17. INFORMANT Elvira Chandler ADDRESS 231 - Rt. 1 Fredericksburg, VA.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Gun shot wound of head 955X DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 976X					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		21b. TIME OF INJURY Month, Day, Year 9:17pm 7-13- 19 68		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) Shot self in head	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) home		21f. LOCATION Street or R.F.D. No. City or Town County State same as # 13	
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input checked="" type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE EXAMINER'S NAME (Type) John Kehoe MD		M.D. Riverdale, Md.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> ADDRESS (Street, city, town, or county)	
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE 7-19-68		23c. NAME OF CEMETERY OR CREMATORY CULPEPPER NAT'L C. Culpepper VA.	
24. FUNERAL DIRECTOR W.W. Chambers Co. Riverdale Md.		25a. REC'D BY REGISTRAR DATE JUL 18 1968		25b. REGISTRAR'S SIGNATURE J. Charles Judge	

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File Pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 42 hours after death.

10423 DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10432

1. DECEASED-NAME (Type or Print)			First Middle Last			2a. DATE KNOWN OF ESTI- DEATH MATED <input checked="" type="checkbox"/> 7-13-68			2b. HOUR 199:15pm M		
Joanne Louise Chandler											
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (In years last birthday)	IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.		2c. DATE PRONOUNCED DEAD Month Day Year			2d. HOUR
Female	White	1-11-1931	37 YRS.					7 Month 13 Day 68 Year			9:50pm M
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Prince George's Md.					
MARYLAND		U.S.									
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)			12b. KIND OF BUSINESS OR INDUSTRY		
Bladensburg			4275 58th. Avenue								
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE			13b. COUNTY			13c. CITY OR TOWN			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		
Maryland			Prince George			Bladensburg			4275 58th. Avenue		
14. FATHER'S NAME First Middle Last			15. MOTHER'S MAIDEN NAME First Middle Last								
ROGER ALLEN			LOUISE DONOVAN								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16b. SOCIAL SECURITY NO.			17. INFORMANT ADDRESS					
NO						WILLIAM H. BORR BAUGH RIVERDALE MD.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Gun shot wound of head</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 981X											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY Month, Day, Year HOUR A.M. 9:15am 7-13-19 68			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) Shot during altercation.					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>			21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) home			21f. LOCATION Street or R.F.D. No. City or Town County State same as #13					
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE			EXAMINER'S NAME (Type)			CHIEF MEDICAL EXAMINER <input type="checkbox"/>			22b. DATE SIGNED		
John Kehoe			John Kehoe MD			DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			7-14-68		
			Riverdale, Md.			ADDRESS (Street, city, town, or county)					
23a. BURIAL, CREMATION, REMOVAL (Specify)			23b. DATE			23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION (City or Town) (County) (State)		
Burial			7-18-68			St. Lincol			Columb Manor Md.		
24. FUNERAL DIRECTOR			ADDRESS			25a. REC'D BY REGISTRAR DATE			25b. REGISTRAR'S SIGNATURE		
W.W. Chamber Co. Riverdale Md.						JUL 19 1968			J Charles Judge		

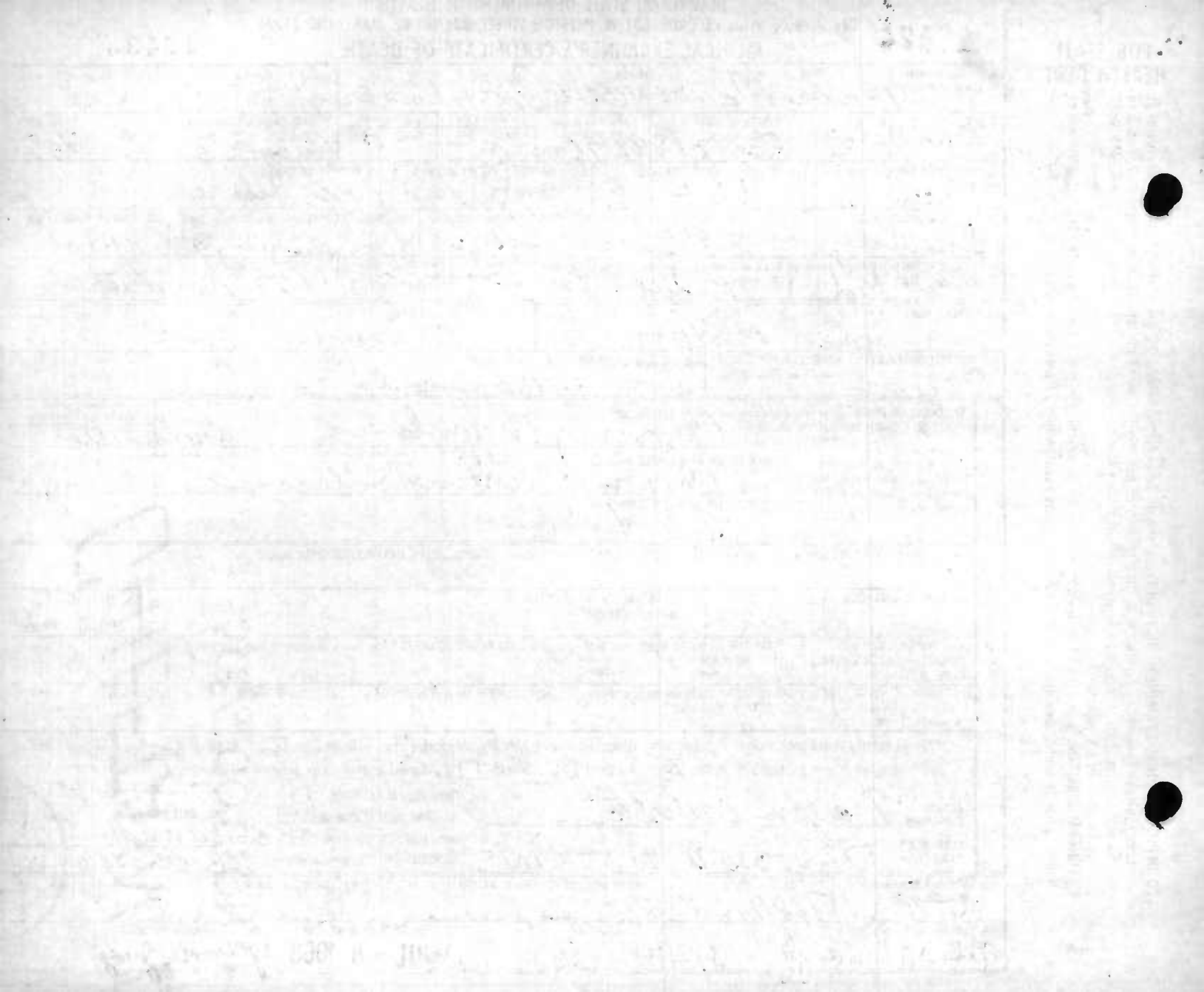
JUL 1 1968

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
MEDICAL EXAMINER'S CERTIFICATE OF DEATH									
1. DECEASED-NAME (Type or Print) JAMES MENDENHALL CHISHOLM Sr			First Middle Last			2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> Month <input type="checkbox"/> Day <input type="checkbox"/> Year July 5 1968			2b. HOUR M
3. SEX M	4. RACE W	5. DATE OF BIRTH Dec 7 1891	6. AGE (In years last birthday) 76 YRS.	IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.	2c. DATE PRONOUNCED DEAD July 5 1968			2d. HOUR 22 AM
7a. BIRTHPLACE (State or foreign country) Scarsdale		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Pr Georges			Md.
10. CITY OR TOWN OF DEATH Cheverly			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Prince Georges Auto Salesmen Kit			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)			12b. KIND OF BUSINESS OR INDUSTRY auto
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Md			13b. COUNTY Pr Geo Edmonston			13d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO			13e. STREET AND NUMBER 5107 Decatur
14. FATHER'S NAME James M NETTLES			First Middle Last			15. MOTHER'S MAIDEN NAME Christina Ford			First Middle Last
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, unknown) No			(If yes give war or dates of service)			16b. SOCIAL SECURITY NO.			17. INFORMANT ADDRESS Police records
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Thrombosis 4100 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Coronary Arterio Sclerosis DUE TO, OR AS A CONSEQUENCE OF (c) Hypertension APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH few minute									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) 4201									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)			21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>									
ACTUAL SIGNATURE Dayton O Walker			M.D.			CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			22b. DATE SIGNED 7-5-68
EXAMINER'S NAME (Type) DAYTON O WATKINS			ADDRESS (Street, city, town, or county) 5318 Annapolis Rd			ADDRESS (Street, city, town, or county) Bladensburg Rd			
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE 7/8/1968		23c. NAME OF CEMETERY OR CREMATORY Congressional		23d. LOCATION (City or Town) (County) (State) Wash. D.C.			
24. FUNERAL DIRECTOR Robert A Mattingly			ADDRESS 131-174 St. E. Wash. D.C.			25a. REC'D BY REGISTRAR JUL - 8 1968			25b. REGISTRAR'S SIGNATURE J Charles Judge



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

10425										DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										10434																																							
1. DECEASED-NAME (Type or print)										20. DATE OF DEATH										2b. HOUR																																							
First Middle Last										Month Day Year																																																	
CATHERINE RUSSEL CHRISTOPHER										July 6 1968										3:10 PM																																							
3. SEX										4. RACE										5. DATE OF BIRTH										6. AGE (In years last birthday)										IF UNDER 1 YEAR MONTHS DAYS										IF UNDER 24 HRS. HOURS MIN.									
Female										White										2/20/1899										69 YRS.																													
7a. BIRTHPLACE (State or foreign country)										7b. CITIZEN OF WHAT COUNTRY?										8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>										9. COUNTY OF DEATH										Md.																			
Iowa										U.S.A.																				Prince Georges																													
10. CITY OR TOWN OF DEATH										11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)										12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)										12b. KIND OF BUSINESS OR INDUSTRY																													
Hyattsville										Hyattsville Nursing Home										Retired schoolteacher																																							
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE										13b. COUNTY										13c. CITY OR TOWN										13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>										13e. STREET AND NUMBER																			
D.C.																				Washington										YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>										1600 - 16th St., N.W.																			
14. FATHER'S NAME										15. MOTHER'S MAIDEN NAME																																																	
First Middle Last										First Middle Last																																																	
James G. Russel										Fannie Filson																																																	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown)										16b. SOCIAL SECURITY NO.										17. INFORMANT										Address																													
no										577-52-2850										Nursing Home Records										same as above																													
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)										PART I. DEATH WAS CAUSED BY:										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH																																							
IMMEDIATE CAUSE (a)										DUE TO, OR AS A CONSEQUENCE OF										2 days																																							
1579										Pneumonia																																																	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.										(b)										2 days																																							
										Indistinct obstruction																																																	
										(c)										diagnosed 9/67																																							
										Adenocarcinoma of Pancreas																																																	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)																																																											
157X										cachexia																																																	
19a. DATE OF OPERATION										19b. CONDITION FOR WHICH OPERATION WAS PERFORMED										20a. AUTOPSY?										20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?																													
10/2/67										Obstructive jaundice										YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>																																							
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)										21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19										21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)																																							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>										21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)										21f. LOCATION Street or R.F.D. No. City or Town County State																																							
22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to 7/6, 1968, that (I) (we) last saw the deceased alive on 7/6, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.																																																											
22b. SIGNATURE										M.D. DEGREE										ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>										22c. DATE SIGNED																													
Edw S Mehlman																														7/6/68																													
22d. PHYSICIAN'S NAME (Type)										22e. ADDRESS																																																	
Edward S. Mehlman, M.D.										MEDICAL ARTS BUILDING																																																	
										6480 NEW HAMPSHIRE AV. TAKOMA PK, Md.																																																	
23a. BURIAL, CREMATION, REMOVAL (Specify)										23b. DATE										23c. NAME OF CEMETERY OR CREMATORY										23d. LOCATION (City or Town) (County) (State)																													
burial										7/10/68										Cedar Hill Cemetery										Prince Georges Co. Md.																													
24. FUNERAL DIRECTOR										24a. ADDRESS										24b. REC'D BY REGISTRAR										24c. REGISTRAR'S SIGNATURE																													
The S. H. Hines Co.										2901 14th St. N. S. Washington DC										JUL - 9 1968										Charles Judge																													

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CERTIFICATE OF DEATH

10426

10435

1. DECEASED-NAME (Type or print)		First Glenn G.	Middle Clifton	Last Clifton	2a. DATE OF DEATH Month Day Year July 18 1968		2b. HOUR 7:00 M	
3. SEX Female		4. RACE White		5. DATE OF BIRTH April 19, 1917		6. AGE (In years last birthday) 51 YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.
7a. BIRTHPLACE (State or foreign country) Oklahoma		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Prince George's Md.		
10. CITY OR TOWN OF DEATH Riverdale		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Eugene Leland Memorial		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland		13b. COUNTY Pr. George's		13c. CITY OR TOWN Riverdale		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 4722 Riverdale Rd. 5055 x Washington St.
14. FATHER'S NAME First Middle Last William Robert Mincey		15. MOTHER'S MAIDEN NAME First Middle Last Ora U. Legg		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) (If yes give war or dates of service) No None Unknown				
16b. SOCIAL SECURITY NO. Unknown		17. INFORMANT Address Riverdale, Md.						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pneumonia & Gramicins Curbaris 5710 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 5811 (b) Ch. Alcoholism DUE TO, OR AS A CONSEQUENCE OF (c)		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH						
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) Fx R. Subcut. Abscess								
19a. DATE OF OPERATION 7-14-68		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED ↑		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)				
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No. City or Town County State				
22a. I certify that (I) (this hospital) attended the deceased from 7-14 , 19 68 , to 7-18 , 19 68 , that (I) (we) last saw the deceased alive on 7-18 , 19 68 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.								
22b. SIGNATURE Lloyd H. Scribner M.D.		22c. DATE SIGNED 7-18-68		22d. PHYSICIAN'S NAME (Type) LLOYD H. SCRIBNER				
22e. ADDRESS 831 UNION BLVD. E. SILVER								
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 7/22/68		23c. NAME OF CEMETERY OR CREMATORY Glen Haven Mem'l Park		23d. LOCATION (City or Town) (County) (State) Glen Burnie, Md.		
24. FUNERAL DIRECTOR Robert P. Ware		24a. REC'D BY REGISTRAR JUL 22 1968		24b. REGISTRAR'S SIGNATURE J. Charles Judge				

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. at Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR 115
30M REV 7-68

10427										DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										10436									
1. DECEASED-NAME (Type or print)										2a. DATE OF DEATH										2b. HOUR									
First Middle Last FRANK M. CLOWER										July 11, 1968										10 PM									
3. SEX			4. RACE			5. DATE OF BIRTH			6. AGE (In years last birthday)			IF UNDER 1 YEAR			IF UNDER 24 HRS.														
M			W			Oct 11, 1905			68 YRS.			MONTHS DAYS			HOURS MIN.														
7a. BIRTHPLACE (State or foreign country)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED			9. COUNTY OF DEATH																				
MARYLAND			U.S.			NEVER MARRIED			PR Geo																				
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)			12b. KIND OF BUSINESS OR INDUSTRY																				
Cheverly, Md			PR Geo GEN			Superintendent			CONSTR																				
13a. USUAL RESIDENCE (Where deceased lived, if institution, residence before admission) STATE			13b. COUNTY			13c. CITY OR TOWN			13d. INSIDE CITY LIMITS			13e. STREET AND NUMBER																	
Md			PR Geo			College Park			NO			5007 Hollywood Rd																	
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME																										
First Middle Last HUGH CLOWER			First Middle Last UNKNOWN O'NEIL																										
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown)			16b. SOCIAL SECURITY NO.			17. INFORMANT			Address																				
No			579101083			Virginia Clower			(wife)			same																	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH																			
PART 1. DEATH WAS CAUSED BY:																													
IMMEDIATE CAUSE (a)										4120																			
DUE TO, OR AS A CONSEQUENCE OF										Myocardial failure																			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.										(b) Hypertensive Encephalopathy																			
DUE TO, OR AS A CONSEQUENCE OF										(c) Hypertensive Arteriosclerotic Cardiovascular disease																			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)										443x																			
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?																				
						YES NO																							
21a. ACCIDENT WAS UNDERLYING			21b. TIME OF INJURY			21c. HOW INJURY OCCURRED																							
<input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			HOUR A.M. Month Day Year P.M. 19			Enter nature of injury in Part 1 or Part 2, Item 18.)																							
21d. INJURY OCCURRED			21e. PLACE OF INJURY			21f. LOCATION			City or Town			County			State														
While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work			(AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			Street or R.F.D. No.			Jan 1968			July 1968																	
22a. I certify that (I) (this hospital) attended the deceased from Jan 1968, to July 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.																													
22b. SIGNATURE										22c. DATE SIGNED																			
W. L. Etienne										7-11-68																			
22d. PHYSICIAN'S NAME (Type)										22e. ADDRESS																			
W. L. ETIENNE										College Park Md.																			
23a. BURIAL, CREMATION, REMOVAL (Specify)			23b. DATE			23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION (City or Town)			(County)			(State)														
BURIAL			July 15, 1968			FT. LINCOLN CEM			COLMAR MANOR			MARYLAND																	
24. FUNERAL DIRECTOR										25a. REC'D BY REGISTRAR										25b. REGISTRAR'S SIGNATURE									
W. W. Chambers Co Riverdale, Md.										JUL 17 1968										Charles Judge									

**FOR STATE
HEALTH DEPT.**

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										
<div style="display: flex; justify-content: space-between;"> 10428 10437 </div> <p align="center">MEDICAL EXAMINER'S CERTIFICATE OF DEATH</p>										
1. DECEASED-NAME (Type or Print) First Middle Last Joseph Michael Coffey						2a. DATE KNOWN OF DEATH Month Day Year 7-21-68		2b. HOUR M 11:31am		
3. SEX Male	4. RACE White	5. DATE OF BIRTH 9-22-1946	6. AGE (In years last birthday) 21 YRS.	IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS HOURS MIN	2c. DATE PRONOUNCED DEAD Month Day Year 7 21 68		2d. HOUR M 12:58am		
7a. BIRTHPLACE (State or foreign country) Illinois		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Prince George's Md.				
10. CITY OR TOWN OF DEATH Cheverly			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Prince George Hospital			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Roofing		12b. KIND OF BUSINESS OR INDUSTRY		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland			13b. COUNTY Montgomery		13c. CITY OR TOWN Kensington		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 2900 Jennings Road	
14. FATHER'S NAME First Middle Last Harry J. Coffey				15. MOTHER'S MAIDEN NAME First Middle Last Rose T. Salvatore						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes			16b. SOCIAL SECURITY NO. 0731764 330 38 0496		17. INFORMANT ADDRESS Mrs. Mary L. Coffey Same as # 13					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Gun shot wound of abdomen 955 X DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 981X										
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY Month, Day, Year HOUR A.M. 1:30am 7-21- 19 68		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) Shot during altercation						
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input checked="" type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) 5138 Livingston Terrace		21f. LOCATION Street or R.F.D. No. City or Town County State Apt. 302, Prince George's County, Maryland						
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/>										
ACTUAL SIGNATURE John Kehoe EXAMINER'S NAME (Type) John Kehoe MD				M.D. Riverdale, Md.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		22b. DATE SIGNED 7-22-68		
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE July 25-68		23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery		23d. LOCATION (City or Town) (County) (State) Suitland, Maryland				
24. FUNERAL DIRECTOR Simmons Bros. ADDRESS 1661-Gg. Hope Rd. SE. DC				25a. REC'D BY REGISTRAR JUL 24 1968		25b. REGISTRAR'S SIGNATURE Charles Judge				

1953

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

DATE
TIME

NAME OF DECEASED: [illegible] SEX: [illegible] AGE: [illegible]

DATE OF DEATH: [illegible] TIME OF DEATH: [illegible]

PLACE OF DEATH: [illegible]

CAUSE OF DEATH: [illegible]

MANNER OF DEATH: [illegible]

DATE OF EXAMINATION: [illegible]

SIGNATURE OF EXAMINER: [illegible]

DATE OF SIGNATURE: [illegible]

PLACE OF SIGNATURE: [illegible]

DATE OF DEATH: [illegible]

TIME OF DEATH: [illegible]

PLACE OF DEATH: [illegible]

CAUSE OF DEATH: [illegible]

MANNER OF DEATH: [illegible]

DATE OF EXAMINATION: [illegible]

SIGNATURE OF EXAMINER: [illegible]

DATE OF SIGNATURE: [illegible]

PLACE OF SIGNATURE: [illegible]

John J. [illegible]

JUL 21 1953

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
CERTIFICATE OF DEATH									
1. DECEASED-NAME (Type or print)			First Middle Last			2a. DATE OF DEATH		2b. HOUR	
Norman			H. Collins			July Month 31, Day 1968		12:20A	
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)		IF UNDER 1 YEAR MONTHS DAYS	
Male		Caucasian		April 24, 1892		76 YRS.		IF UNDER 24 HRS. HOURS MIN	
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH		Md.	
Maryland		USA				Prince George's			
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b. KIND OF BUSINESS OR INDUSTRY			
Cheverly		Prince Geo. Gen'l Hospital		Real Estate Broker					
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER	
Maryland		Prince George's		--		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		7618 Marlboro Pike	
14. FATHER'S NAME First Middle Last			15. MOTHER'S MAIDEN NAME First Middle Last						
Frank Collins			Alice Harry						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown (If yes give war or dates of service)			16b. SOCIAL SECURITY NO.		17. INFORMANT Address				
NO			578101977		Edna D. Collins, Same as #13, Wife				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral metastases</u> <u>1621</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>bronchogenic Carcinoma (Right)</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>1621</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) <u>1621</u>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) <u>(this hospital)</u> attended the deceased from <u>7-12-68</u> , to <u>July 31, 1968</u> , that (I) <u>(yes)</u> last saw the deceased alive on <u>July 31, 1968</u> , and that in (my) <u>(own)</u> opinion death occurred on the date and hour and from the causes stated above, (I) <u>(yes)</u> (did) <u>(not)</u> view the body after death.									
22b. SIGNATURE <u>Oliver B. Bond</u>				DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED <u>7-31-68</u>			
22d. PHYSICIAN'S NAME (Type) <u>Oliver Bond, M. D.</u>				22e. ADDRESS <u>6872 Riverdale Rd., Lanham, Maryland</u>					
23a. BURIAL, CREMATION, REBURY (Specify)		23b. DATE <u>8-3-68</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Fort Lincoln Cemetery</u>		23d. LOCATION (City or Town) (County) (State) <u>PG County Maryland</u>			
24. FUNERAL DIRECTOR <u>Wilhelm Funeral Home</u> ADDRESS <u>4308 Suitland Rd. SE, Wash. D.C.</u>				25a. REC'D BY REGISTRAR DATE <u>AUG 3 1968</u>		25b. REGISTRAR'S SIGNATURE <u>Charles J. J...</u>			

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form P-43. 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. Pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (3)
10M REV. 7-68

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or Print)		First		Middle		Last		2a. DATE KNOWN OF ESTI- DEATH MATED <input checked="" type="checkbox"/> 7-28-68		2b. HOUR 192:00am	
Horace		Conner									
3. SEX	4. RACE	5. DATE OF BIRTH		6. AGE (In years last birthday)	IF UNDER 1 YEAR MONTHS		IF UNDER 24 HRS DAYS		2c. DATE PRONOUNCED DEAD Month 7 Day 28 Year 68		2d. HOUR 193:35am
Male	White	9-4-1930		37 YRS.							
7a. BIRTHPLACE (State or foreign country) Tenn.		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Prince George's				Md.	
10. CITY OR TOWN OF DEATH Cheverly		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Prince George Hospital		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Repairman		12b. KIND OF BUSINESS OR INDUSTRY Telephone					
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) - STATE Maryland		13b. COUNTY Prince Georges		13c. CITY OR TOWN Forest Knolls		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 10006 Taylor Ave.			
14. FATHER'S NAME Clyde W. Conner		First		Middle		Last		15. MOTHER'S MAIDEN NAME Kate King		First Middle Last	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) YES		16b. SOCIAL SECURITY NO. 1947-55		17. INFORMANT (Wife) Evelyn M. Conner, Same as #13		ADDRESS					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Gun shot wound of head</u> 955X DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 976X											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY Month, Day, Year HOUR A.M. 2:00am 7-28-68		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) Shot self at home							
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) Home		21f. LOCATION Street or R.F.D. No. Same as #13		City or Town		County		State	
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input checked="" type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE EXAMINER'S NAME (Type)		John Kehoe MD		Riverdale, Md.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		22b. DATE SIGNED 7-29-68		ADDRESS (Street, city, town, or county)	
23a. BURIAL, CREMATION REMOVAL (Specify) Burial		23b. DATE 7-31-68		23c. NAME OF CEMETERY OR CREMATORY Fort Lincoln Cenetery		23d. LOCATION (City or Town) PG County, Maryland		(County)		(State)	
24. FUNERAL DIRECTOR Wilhelm Funeral Home 4308 Suitland Rd. SE, Suitland, Maryland						25a. REC'D BY REGISTRAR AUG 1 1968		25b. REGISTRAR'S SIGNATURE J Charles Judge			

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RECORDS SECTION

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
CERTIFICATE OF DEATH									
1. DECEASED-NAME (Type or print) First <i>Ambrose</i> Middle <i>James</i> Last <i>Gox</i>					2a. DATE OF DEATH Month <i>7</i> Day <i>5</i> Year <i>1968</i>		2b. HOUR M <i></i>		
3. SEX MALE		4. RACE CAU.		5. DATE OF BIRTH <i>Dec 4 1881</i>		6. AGE (In years lost birthday) <i>86</i> YRS.		IF UNDER 1 YEAR MONTHS <i></i> DAYS <i></i>	
7a. BIRTHPLACE (State or foreign country) NEW YORK		7b. CITIZEN OF WHAT COUNTRY? U.S.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH PRINCE GEORGE		Md.	
10. CITY OR TOWN OF DEATH SEABROOK		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) 9520 Annapolis Rd.			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Ret. Mach		12b. KIND OF BUSINESS OR INDUSTRY U.S. GOV'T		
13a. USUAL RESIDENCE (Where deceased admission) STATE MARYLAND		13b. CITY OR TOWN PRINCE GEORGE		13c. CITY OR TOWN SEABROOK		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 9520 Annapolis Rd.	
14. FATHER'S NAME Unknown			15. MOTHER'S MAIDEN NAME unknown						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no		16b. SOCIAL SECURITY NO. 220-44-4654		17. INFORMANT Annie R. Cox Wife		Address Same as above			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Heart failure</i> DUE TO, OR AS A CONSEQUENCE OF (b) <i>arteriosclerotic heart disease</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i>generalized arteriosclerosis</i>								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>Days</i> <i>years</i> <i>years</i>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <i>4200 Diabetes Mellitus</i>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <i>19</i>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from <i>7/5</i> , 19 <i>68</i> , to <i>7/5</i> , 19 <i>68</i> , that (I) (we) lost saw the deceased alive on <i>7/5</i> , 19 <i>68</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <i>James Kurtz MD</i>				DEGREE MD		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED	
22d. PHYSICIAN'S NAME (Type) H. James Kurtz				22e. ADDRESS RT-D glenn Oak Md					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 7/8/68		23c. NAME OF CEMETERY OR CREMATORY Ft. Lincoln		23d. LOCATION (City or Town) (County) (State) Colmar Manor Maryland			
24. FUNERAL DIRECTOR F. Gasch's Sons				ADDRESS Hyattsville, Md.		25a. REC'D BY REGISTRAR JUL - 8 1968		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	

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Liberty Hall

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(1) 1st 2nd 3rd 4th 5th 6th 7th 8th 9th 10th 11th 12th 13th 14th 15th 16th 17th 18th 19th 20th 21st 22nd 23rd 24th 25th 26th 27th 28th 29th 30th 31st 32nd 33rd 34th 35th 36th 37th 38th 39th 40th 41st 42nd 43rd 44th 45th 46th 47th 48th 49th 50th 51st 52nd 53rd 54th 55th 56th 57th 58th 59th 60th 61st 62nd 63rd 64th 65th 66th 67th 68th 69th 70th 71st 72nd 73rd 74th 75th 76th 77th 78th 79th 80th 81st 82nd 83rd 84th 85th 86th 87th 88th 89th 90th 91st 92nd 93rd 94th 95th 96th 97th 98th 99th 100th 101st 102nd 103rd 104th 105th 106th 107th 108th 109th 110th 111th 112th 113th 114th 115th 116th 117th 118th 119th 120th 121st 122nd 123rd 124th 125th 126th 127th 128th 129th 130th 131st 132nd 133rd 134th 135th 136th 137th 138th 139th 140th 141st 142nd 143rd 144th 145th 146th 147th 148th 149th 150th 151st 152nd 153rd 154th 155th 156th 157th 158th 159th 160th 161st 162nd 163rd 164th 165th 166th 167th 168th 169th 170th 171st 172nd 173rd 174th 175th 176th 177th 178th 179th 180th 181st 182nd 183rd 184th 185th 186th 187th 188th 189th 190th 191st 192nd 193rd 194th 195th 196th 197th 198th 199th 200th 201st 202nd 203rd 204th 205th 206th 207th 208th 209th 210th 211th 212th 213th 214th 215th 216th 217th 218th 219th 220th 221st 222nd 223rd 224th 225th 226th 227th 228th 229th 230th 231st 232nd 233rd 234th 235th 236th 237th 238th 239th 240th 241st 242nd 243rd 244th 245th 246th 247th 248th 249th 250th 251st 252nd 253rd 254th 255th 256th 257th 258th 259th 260th 261st 262nd 263rd 264th 265th 266th 267th 268th 269th 270th 271st 272nd 273rd 274th 275th 276th 277th 278th 279th 280th 281st 282nd 283rd 284th 285th 286th 287th 288th 289th 290th 291st 292nd 293rd 294th 295th 296th 297th 298th 299th 300th 301st 302nd 303rd 304th 305th 306th 307th 308th 309th 310th 311th 312th 313th 314th 315th 316th 317th 318th 319th 320th 321st 322nd 323rd 324th 325th 326th 327th 328th 329th 330th 331st 332nd 333rd 334th 335th 336th 337th 338th 339th 340th 341st 342nd 343rd 344th 345th 346th 347th 348th 349th 350th 351st 352nd 353rd 354th 355th 356th 357th 358th 359th 360th 361st 362nd 363rd 364th 365th 366th 367th 368th 369th 370th 371st 372nd 373rd 374th 375th 376th 377th 378th 379th 380th 381st 382nd 383rd 384th 385th 386th 387th 388th 389th 390th 391st 392nd 393rd 394th 395th 396th 397th 398th 399th 400th 401st 402nd 403rd 404th 405th 406th 407th 408th 409th 410th 411th 412th 413th 414th 415th 416th 417th 418th 419th 420th 421st 422nd 423rd 424th 425th 426th 427th 428th 429th 430th 431st 432nd 433rd 434th 435th 436th 437th 438th 439th 440th 441st 442nd 443rd 444th 445th 446th 447th 448th 449th 450th 451st 452nd 453rd 454th 455th 456th 457th 458th 459th 460th 461st 462nd 463rd 464th 465th 466th 467th 468th 469th 470th 471st 472nd 473rd 474th 475th 476th 477th 478th 479th 480th 481st 482nd 483rd 484th 485th 486th 487th 488th 489th 490th 491st 492nd 493rd 494th 495th 496th 497th 498th 499th 500th 501st 502nd 503rd 504th 505th 506th 507th 508th 509th 510th 511th 512th 513th 514th 515th 516th 517th 518th 519th 520th 521st 522nd 523rd 524th 525th 526th 527th 528th 529th 530th 531st 532nd 533rd 534th 535th 536th 537th 538th 539th 540th 541st 542nd 543rd 544th 545th 546th 547th 548th 549th 550th 551st 552nd 553rd 554th 555th 556th 557th 558th 559th 560th 561st 562nd 563rd 564th 565th 566th 567th 568th 569th 570th 571st 572nd 573rd 574th 575th 576th 577th 578th 579th 580th 581st 582nd 583rd 584th 585th 586th 587th 588th 589th 590th 591st 592nd 593rd 594th 595th 596th 597th 598th 599th 600th 601st 602nd 603rd 604th 605th 606th 607th 608th 609th 610th 611th 612th 613th 614th 615th 616th 617th 618th 619th 620th 621st 622nd 623rd 624th 625th 626th 627th 628th 629th 630th 631st 632nd 633rd 634th 635th 636th 637th 638th 639th 640th 641st 642nd 643rd 644th 645th 646th 647th 648th 649th 650th 651st 652nd 653rd 654th 655th 656th 657th 658th 659th 660th 661st 662nd 663rd 664th 665th 666th 667th 668th 669th 670th 671st 672nd 673rd 674th 675th 676th 677th 678th 679th 680th 681st 682nd 683rd 684th 685th 686th 687th 688th 689th 690th 691st 692nd 693rd 694th 695th 696th 697th 698th 699th 700th 701st 702nd 703rd 704th 705th 706th 707th 708th 709th 710th 711th 712th 713th 714th 715th 716th 717th 718th 719th 720th 721st 722nd 723rd 724th 725th 726th 727th 728th 729th 730th 731st 732nd 733rd 734th 735th 736th 737th 738th 739th 740th 741st 742nd 743rd 744th 745th 746th 747th 748th 749th 750th 751st 752nd 753rd 754th 755th 756th 757th 758th 759th 760th 761st 762nd 763rd 764th 765th 766th 767th 768th 769th 770th 771st 772nd 773rd 774th 775th 776th 777th 778th 779th 780th 781st 782nd 783rd 784th 785th 786th 787th 788th 789th 790th 791st 792nd 793rd 794th 795th 796th 797th 798th 799th 800th 801st 802nd 803rd 804th 805th 806th 807th 808th 809th 810th 811th 812th 813th 814th 815th 816th 817th 818th 819th 820th 821st 822nd 823rd 824th 825th 826th 827th 828th 829th 830th 831st 832nd 833rd 834th 835th 836th 837th 838th 839th 8

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
CERTIFICATE OF DEATH									
1. DECEASED-NAME (Type or print)			First	Middle	Last	2a. DATE OF DEATH Month Day Year			2b. HOUR
William			M.		Cunningham	July 20, 1968			3:25AM
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)		IF UNDER 1 YEAR MONTHS	IF UNDER 24 HRS. HOURS MIN.
Male		Caucasian		JAN. 1, 1893		75 YRS.			
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH			
VA.		U.S.A.				Prince George's Md.			
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b. KIND OF BUSINESS OR INDUSTRY	
Cheverly			Prince George's Gen. Hosp.			Gen. Dept.		City of Baltimore	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE			13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER
Maryland			Prince Geo.		Mt. Rainier		YES		4108 33rd St.
14. FATHER'S NAME			First	Middle	Last	15. MOTHER'S MAIDEN NAME			First Middle Last
THOMAS					CUNNINGHAM	UNKNOWN			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no or unknown			16b. SOCIAL SECURITY NO.		17. INFORMANT				Address
NO					Richard B. BATTMAN				8106 PARKBLVD FORESTVIEW, MD.
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)									
PART 1. DEATH WAS CAUSED BY:									
IMMEDIATE CAUSE (a) <u>Massive cerebral hemorrhage, right hemisphere & pons.</u>									
DUE TO, OR AS A CONSEQUENCE OF <u>Bilateral confluent bronchopneumonia,</u>									
(b) <u>pulmonary & lobes, with infarction rt. lower lobe.</u>									
DUE TO, OR AS A CONSEQUENCE OF									
(c) <u>Generalized arteriosclerosis</u>									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)									
331X									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
					YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		Yes		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
		HOUR A.M. Month Day Year P.M. 19							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (X) (this hospital) attended the deceased from <u>July 2</u> , 19 <u>68</u> , to <u>July 20</u> , 19 <u>68</u> , that (X) (we) last saw the deceased alive on <u>July 20</u> , 19 <u>68</u> , and that in (our) opinion death occurred on the date and hour and from the causes stated above. (X) (we) (did) (not see) view the body after death.									
22b. SIGNATURE					22c. DATE SIGNED				
Donald C. Edglen M.D.					7-20-68				
22d. PHYSICIAN'S NAME (Type)					22e. ADDRESS				
DONALD C. EDGLEN					Ayattsville, Md.				
23a. BURIAL, CREMATION REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)			
Buried		7-22-68		St. Lincoln		Columbia Manor Md			
24. FUNERAL DIRECTOR					25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE		
W.A. Chamber Co. Riverside					AUG 23 1968		Charles Judge		

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FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME
10M REV. 1-64

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
<div style="display: flex; justify-content: space-between;"> 10433 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 10442 </div>									
1. DECEASED-NAME (Type or Print) William Warren Curry					2a. DATE KNOWN OF DEATH <input type="checkbox"/> Month <input type="checkbox"/> Day <input type="checkbox"/> Year July 7 68			2b. HOUR M	
3. SEX M	4. RACE W	5. DATE OF BIRTH July 2, 1968	6. AGE (In years last birthday) 5 YRS.	IF UNDER 1 YEAR MONTHS 5 DAYS	IF UNDER 24 HRS HOURS 5 MIN	2c. DATE PRONOUNCED DEAD Month July Day 7 Year 68		2d. HOUR 4:20 a.m.	
7a. BIRTHPLACE (State or foreign country) Md.		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Prince Georges Md.			
10. CITY OR TOWN OF DEATH Riverdale		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Eugene L. Land Memorial			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Child		12b. KIND OF BUSINESS OR INDUSTRY		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Md.		13b. COUNTY Pr. Geo.		13c. CITY OR TOWN Hyattsville		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 4520 Kennedy St.	
14. FATHER'S NAME First Douglas Middle L. Last Curry				15. MOTHER'S MAIDEN NAME First Alice Middle Irving Last Irving					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO			16b. SOCIAL SECURITY NO. (If yes give war or dates of service)		17. INFORMANT ADDRESS Douglas L. Curry Father Same as above				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary Atelectosis 7769 DUE TO, OR AS A CONSEQUENCE OF (b) SDTT DUE TO, OR AS A CONSEQUENCE OF (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Few minutes
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) 7620									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		21b. TIME OF INJURY Month, Day, Year 19 HOUR A.M. P.M.		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>									
ACTUAL SIGNATURE Dayton O. Watkins		EXAMINER'S NAME (Type) Dayton O. Watkins		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		7-8-68		22b. DATE SIGNED	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 7/10/68		23c. NAME OF CEMETERY OR CREMATORY FT. LINCOLN		23d. LOCATION (City or town) (County) (State) COLMAR MANOR MARYLAND		23e. ADDRESS (Street, city, town, or county) 5318 Annapolis Rd., Bladensburg, Md.	
24. FUNERAL DIRECTOR ADDRESS F. GASCH'S SONS HYATTSVILLE, MARYLAND				25a. REC'D BY REGISTRAR DATE JUL 11 1968		25b. REGISTRAR'S SIGNATURE Charles J. Jones			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. DECEASED-NAME (Type or print)		First	Middle	Lost	2a. DATE OF DEATH Month Day Year			2b. HOUR AM PM	
Mary			H.	Davis	July 14 1968			10:55	
3. SEX	4. RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.
Female	Cauc.		Nov. 6, 1885		85 82 YRS.				
7a. BIRTHPLACE (State or foreign country)	7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH				
Pennsylvania	U.S.A.				Prince George Md.				
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of waking life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY				
Hyattsville	Hyattsville Nursing Home		Housewife		Own Home				
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)	13b. COUNTY		13c. CITY OR TOWN	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET AND NUMBER				
Maryland	Prince George		Hyattsville		814 Rittenhouse Street				
14. FATHER'S NAME	First	Middle	Lost	15. MOTHER'S MAIDEN NAME		First	Middle	Lost	
David			Davies	Catherine				(Unknown)	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown		16b. SOCIAL SECURITY NO. (If yes give war or dates of service)		17. INFORMANT		2224 Charleston Place Hyattsville, Md.			
no		yes		Mr. Raymond W. Davis					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pneumonia</u> 402 X DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>senility</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>hypertensive heart disease</u>									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) 443X									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No.		City or Town		County	State
22a. I certify that (I) (this hospital) attended the deceased from 5-30, 1968 to 7-14, 1968, that (I) (we) lost the deceased alive on 7-13, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE Dr. Margaret J. Snow MD				DEGREE		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED 7-14-68	
22d. PHYSICIAN'S NAME (Type) Dr. Margaret J. Snow				22e. ADDRESS 9013 Flower Avenue, Silver Spring, Md.					
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town)		(County)	(State)
Burial		July 17, 1968		Cedar Hill Cemetery		Suitland, Maryland			
24. FUNERAL DIRECTOR Warner E. Pumphrey, Inc. Silver Spring, Md.				25a. REC'D BY REGISTRAR DATE JUL 19 1968		25b. REGISTRAR'S SIGNATURE Charles Yung			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
CERTIFICATE OF DEATH									
1. DECEASED-NAME (Type or print) First Middle Last James J. Dent					2a. DATE OF DEATH Month Day Year 7 28 68			2b. HOUR M	
3. SEX Male		4. RACE Negro		5. DATE OF BIRTH 9-8-08		6. AGE (In years last birthday) 60/59 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (State or foreign country) D.C.		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Prince George's Md.			
10. CITY OR TOWN OF DEATH Cheverly		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) DOA-Prince Geo.Gen'l Hospital				12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Laborer		12b. KIND OF BUSINESS OR INDUSTRY County	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland		13b. COUNTY Prince George's		13c. CITY OR TOWN Forrestville		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 8611 West Fhalia Rd.	
14. FATHER'S NAME First Middle Last Arthur Dent				15. MOTHER'S MAIDEN NAME First Middle Last Unknown					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown no (If yes give war or dates of service)				16b. SOCIAL SECURITY NO. 579-14-6973		17. INFORMANT Address Wife 8611 Westphalia Rd.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) metastatic Carcinoma to liver 1519 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 151X (b) Carcinoma of Stomach DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3 mos 6 mos									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) Coronary Heart Disease									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19 7/28/68			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)				
21d. INJURY OCCURRED While <input type="checkbox"/> Nat while <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State				
22a. I certify that (I) (this hospital) attended the deceased from Aug 1967 to 7/28 , 19 68 , that (I) (we) saw the deceased alive on 7/28/68 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (didn't) view the body after death.									
22b. SIGNATURE Henry A. Wise					DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED 7/29/68		
22d. PHYSICIAN'S NAME (Type) Henry A. Nise, Jr.					22e. ADDRESS 9005 Volta St, Lanham, Md.				
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE 7-31-68		23c. NAME OF CEMETERY OR CREMATORY St. Luke's Cemetery		23d. LOCATION (City or Town) (County) (State) Meadows Md.			
24. FUNERAL DIRECTOR Rollins, Inc. 4339 Hunt Pl., N.E., DC					25a. REC'D BY REGISTRAR JUL 30 1968		25b. REGISTRAR'S SIGNATURE Charles J. [Signature]		

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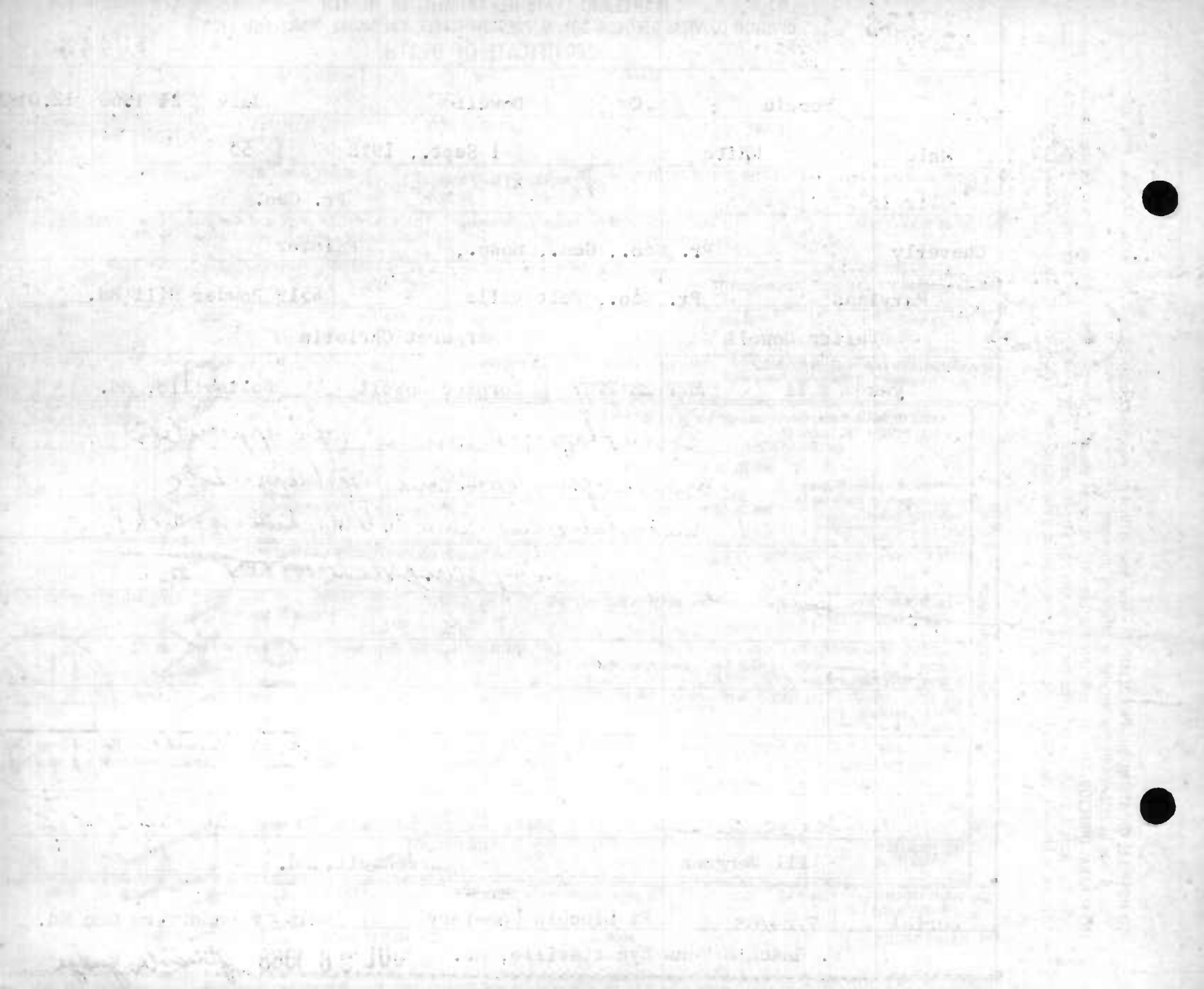
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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

10436 Item#5, Film G40388/1/68 km												DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201												10445											
1. DECEASED-NAME (Type or print) First Middle Last Woodie C Dowell												2a. DATE OF DEATH Month Day Year July 20 1968												2b. HOUR 12.01 AM											
3. SEX Male				4. RACE White				5. DATE OF BIRTH 1 Sept., 1918 17				6. AGE (In years lost birthday) 50 YRS.				IF UNDER 1 YEAR MONTHS DAYS				IF UNDER 24 HRS. HOURS MIN															
7a. BIRTHPLACE (State or foreign country) Virginia				7b. CITIZEN OF WHAT COUNTRY? US A				8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				9. COUNTY OF DEATH Pr. Geo. Md																							
10. CITY OR TOWN OF DEATH Cheverly				11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Pr. Geo., Gen., Hosp.,				12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Painter				12b. KIND OF BUSINESS OR INDUSTRY																							
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland				13b. COUNTY Pr. Geo.,				13c. CITY OR TOWN Beltsville				13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				13e. STREET AND NUMBER 4519 Powder Mill Rd.																			
14. FATHER'S NAME First Middle Last Walter Dowell				15. MOTHER'S MAIDEN NAME First Middle Last Margaret Christin																															
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown Yes W W 11				16b. SOCIAL SECURITY NO. 577 28 7727				17. INFORMANT Bernice Dowell								Address Beltsville, Md.																			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH CAUSED BY: IMMEDIATE CAUSE (a) <u>Bronchopneumonia right upper lobe.</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Bronchiogenic carcinoma, right upper lobe</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>metastatic carcinoma to liver, kidneys, spleen.</u> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH																																			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <u>Bilateral pulmonary emphysema + edema.</u>																																			
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?																							
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)				21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19				21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)																											
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)				21f. LOCATION Street or R.F.D. No. City or Town County State																											
22a. I certify that (I) (this hospital) attended the deceased from <u>July 14</u> , 19 <u>68</u> , to <u>July 21</u> , 19 <u>68</u> , that (I) (we) last saw the deceased alive on <u>July 21</u> , 19 <u>68</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.																																			
22b. SIGNATURE <u>Till Bergman</u>				DEGREE ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>				22c. DATE SIGNED <u>July 21/68</u>																											
22d. PHYSICIAN'S NAME (Type) Till Bergman				22e. ADDRESS Greenbelt, Md.																															
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial				23b. DATE 7/24/68				23c. NAME OF CEMETERY OR CREMATORY Ft Lincoln Cemetery				23d. LOCATION (City or Town) (County) (State) Colmar Manor Pr Geo Md.																							
24. FUNERAL DIRECTOR F. Gasch's Sons				ADDRESS Hya ttsville, Md.				25a. REC'D BY REGISTRAR DATE JUL 26 1968				25b. REGISTRAR'S SIGNATURE <u>J. Charles Judge</u>																							



10437

10446

CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or print) Helen K. Downes			2a. DATE OF DEATH Month July Day 19 Year 1968			2b. HOUR 12:15 M			
3. SEX Female		4. RACE Caucasian		5. DATE OF BIRTH 8/30/1899		6. AGE (In years last birthday) 68 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (State or foreign country) Md		7b. CITIZEN OF WHAT COUNTRY? U S A		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Prince George's Md.			
10. CITY OR TOWN OF DEATH Cheverly		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Prince Geo. Gen'l H^{ospital}		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Housewife		12b. KIND OF BUSINESS OR INDUSTRY own home			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland		13b. COUNTY Prince George's		13c. CITY OR TOWN Lanham		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 6170 Princess Garden Pkwy.	
14. FATHER'S NAME First Walter Warren Brines Middle Brines Last Brines			15. MOTHER'S MAIDEN NAME First Violetta Smith Middle Smith Last Smith						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown --- (If yes give war or dates of service)			16b. SOCIAL SECURITY NO.		17. INFORMANT Richard Downes Address Lanham Md.				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral thrombosis 4330 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Hypertension, essential DUE TO, OR AS A CONSEQUENCE OF (c)								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) 332									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) did not attended the deceased from July 19, 1968 to July 19, 1968 , that (I) was last saw the deceased alive on July 19, 1968 , and that in (my) own opinion death occurred on the date and hour and from the causes stated above, (I) was (did) not view the body after death.									
22b. SIGNATURE Donald C. Edgeman		DEGREE MD		ATTENDING PHYS. <input checked="" type="checkbox"/>		MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED 7-20-68	
22d. PHYSICIAN'S NAME (Type) DONALD C. EDGEMAN		22e. ADDRESS Prince George's Plaza, Hyattsville, Md.							
23a. BURIAL, CREMATION, REINTERMENT Buried		23b. DATE July 22, 1968		23c. NAME OF CEMETERY OR CREMATORY St Thomas Episcopal		23d. LOCATION (City or Town) (County) Croom Pro Geo Md.		23e. REGISTRAR'S SIGNATURE Charles Judge	
24. FUNERAL DIRECTOR F. Gasch's Sons		ADDRESS Hyattsville, Md.		25a. REC'D BY REGISTRAR JUL 23 1968		25b. REGISTRAR'S SIGNATURE Charles Judge			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 2 and 3 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

10438										DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										10447														
1. DECEASED-NAME (Type or print)										2a. DATE OF DEATH										2b. HOUR														
First Middle Last Sylvene R. Dreyer										Month Day Year July 21 68										45 5 A. M.														
3. SEX Female					4. RACE white					5. DATE OF BIRTH MARCH 13, 1879					6. AGE (In years last birthday) 89 YRS.					IF UNDER 1 YEAR MONTHS DAYS					IF UNDER 24 HRS. HOURS MIN.									
7a. BIRTHPLACE (State or foreign country) Baltimore Md.					7b. CITIZEN OF WHAT COUNTRY? U. S. A.					8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>					9. COUNTY OF DEATH Prince Georges Md.																			
10. CITY OR TOWN OF DEATH Hyattsville, Md.					11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Hyattsville Nursing Home					12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Housewife					12b. KIND OF BUSINESS OR INDUSTRY																			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland					13b. COUNTY Prince Georges					13c. CITY OR TOWN Riverdale					13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>					13e. STREET AND NUMBER 5005 Oaklithorpe														
14. FATHER'S NAME First Middle Last William Reiser					15. MOTHER'S MAIDEN NAME First Middle Last Magdalene Gentner					16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, No (If yes give war or dates of service)										16b. SOCIAL SECURITY NO. 219-54-9365					17. INFORMANT Dreyer, Carolee					Address 630 Sheridan St Hyattsville, Md.				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4369 Cerebral vascular accident DUE TO, OR AS A CONSEQUENCE OF (b) Arteriosclerosis DUE TO, OR AS A CONSEQUENCE OF (c) 331X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 20 hrs. 10 yrs.																								
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) Recurrent cystitis & pyelonephritis.																																		
19a. DATE OF OPERATION					19b. CONDITION FOR WHICH OPERATION WAS PERFORMED					20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?																			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)					21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19					21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)																								
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>					21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)					21f. LOCATION Street or R.F.D. No. City or Town County State																								
22a. I certify that (this hospital) attended the deceased from 4-28, 1967, to 7-21, 1968, that (we) last saw the deceased alive on 7-20, 1968, and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I (we) did (did not) view the body after death.										22b. SIGNATURE R.D. Bauer M.D.										22c. DATE SIGNED 7-21-68														
22d. PHYSICIAN'S NAME (Type) R.D. Bauer, M.D.					22e. ADDRESS 2513 Buck Lodge Rd. - Alephi, P.O. Md.																													
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial					23b. DATE July 24, 1968					23c. NAME OF CEMETERY OR CREMATORY Rock Creek Cemetery					23d. LOCATION (City or Town) (County) (State) Washington, D.C.																			
24. FUNERAL DIRECTOR Warner E. Pumphrey, Inc.					25a. REC'D BY REGISTRAR DATE JUL 25 1968					25b. REGISTRAR'S SIGNATURE Charles Judge																								

1-7-7-1

CERTIFICATE OF DEATH

10439

10448

1. DECEASED NAME (Type or print) NEWBORN		First DOUGLAS	Middle DEAN	Last DYER	2a. DATE OF DEATH Month JUL Day 28 Year 68		2b. HOUR 4:00 AM
3. SEX MALE	4. RACE CAUC	5. DATE OF BIRTH 27 JUL 68			6. AGE (In years last birthday) YRS. 1 MONTHS 2 DAYS 31	IF UNDER 1 YEAR IF UNDER 24 HRS.	
7a. BIRTHPLACE (State or foreign country) Md.	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Prince Georges Md.			
10. CITY OR TOWN OF DEATH Camp Springs	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Malcom Grow USAF Hosp.		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Md.	13b. CITY OR TOWN Prince Georges	13c. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13d. STREET AND NUMBER 7435 Keystone Lane				
14. FATHER'S NAME First TERRY Middle GENE Last DYER		15. MOTHER'S MAIDEN NAME First MINNIE Middle LOIS Last ODAM					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown NO		16b. SOCIAL SECURITY NO. na		17. INFORMANT FORESTVILLE MD TERRY G DYER 7435 KEYSTONE LN #102			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Respiratory Arrest 7762 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Respiratory Distress Syndrome DUE TO, OR AS A CONSEQUENCE OF (c) Prematurity APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 14 hr 1 hr							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) 7735							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from 27 Jul , 19 68 , to 28 Jul , 19 68 , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on 28 Jul , 19 68 and that in <input checked="" type="checkbox"/> (my) (our) opinion death occurred on the date and hour and from the causes stated above, <input checked="" type="checkbox"/> (we) (do) (did not) view the body after death.							
22b. SIGNATURE Paul H. Kenzer M.D.				22c. DATE SIGNED 28 July			
22d. PHYSICIAN'S NAME (Type) PAUL H. KENZER M.D.				22e. ADDRESS USAF HOSP Andrews.			
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE 8/9/68		23c. NAME OF CEMETERY OR CREMATION Washington D.C.		23d. LOCATION (City or Town) (County) (State) Washington D.C.	
24. FUNERAL DIRECTOR Carl F. Conforti				25a. REC'D BY REGISTRAR DATE AUG 1 1968		25b. REGISTRAR'S SIGNATURE Charles Judge	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. When please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

10440		DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201				10449	
CERTIFICATE OF DEATH							
1. DECEASED-NAME (Type or print) First <u>TAMMIE</u> Middle <u>JEAN</u> Last <u>DYER</u> NEWBORN FEMALE			2a. DATE OF DEATH Month <u>July</u> Day <u>28</u> Year <u>1968</u>			2b. HOUR <u>0429</u> M	
3. SEX <u>FEMALE</u>		4. RACE <u>Cau.</u>		5. DATE OF BIRTH <u>27 July 68</u>		6. AGE (In years last birthday) YRS. MONTHS DAYS <u>14</u> <u>29</u>	
7a. BIRTHPLACE (State or foreign) <u>Maryland</u>		7b. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH PRINCE GEORGE'S	
10. CITY OR TOWN OF DEATH <u>Andrews AFB</u>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Matcom Grow USAFHosp</u>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <u>Md.</u>		13b. COUNTY <u>Prince Georges</u>		13c. CITY OR TOWN <u>Forrestville</u>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
13e. STREET AND NUMBER <u>7435 Keystone Lane</u>		14. FATHER'S NAME First <u>TERRY</u> Middle <u>GENE</u> Last <u>DYER</u>		15. MOTHER'S MAIDEN NAME First <u>MINNIE</u> Middle <u>LOIS</u> Last <u>ODAM</u>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> (If yes give war or dates of service)		16b. SOCIAL SECURITY NO.		17. INFORMANT <u>FORESTVILLE MD</u> Address <u>#102</u> <u>TERRY G DYER</u> <u>7435 KEYSTONE LN</u> <u>XXXH</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Respiratory & Cardiac Arrest</u> <u>7762</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Prematurity</u> <u>Respiratory Distress Synd.</u> <u>14 hrs 28 min</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Premature Birth</u> <u>14 hrs 28 min</u> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>2 hrs.</u>							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (c) <u>7735</u>							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <u>19</u>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that (I, this hospital) attended the deceased from <u>27 Jul</u> , 19 <u>68</u> , to <u>28 Jul</u> , 19 <u>68</u> , that (I) (we) last saw the deceased alive on <u>28 Jul</u> , 19 <u>68</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <u>Paul H. Penzer MD</u>		22c. DATE SIGNED <u>28 July</u>		22d. PHYSICIAN'S NAME (Type) <u>PAUL H. PENZER MD</u>		22e. ADDRESS <u>USAF Hosp. Andrews</u>	
23a. CREMATION CREMATION, OTHER (Specify)		23b. DATE <u>28 8/9/68</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Washington D.C. Christian</u>		23d. LOCATION (City or Town) (County) (State) <u>Washington D.C.</u>	
24. FUNERAL DIRECTOR <u>Carl E. Ruffert</u>		25a. REC'D BY REGISTRAR <u>AUG 1 1968</u>		25b. REGISTRAR'S SIGNATURE <u>J. Charles Judge</u>			

WINTERBURY TOWN

PRINCE GEORGE'S

U.S.A.

MAINTENANCE

ALCOHOL FROM LABORATORY

ANALYSIS

MINNIE LOIS ORAN

DEER

GENE

TERRY

TERRY & DEER, 1035 ELYSIUM LN, KNOX
FORESTVILLE, MD 21053

27 JUL 1953

27 JUL 1953

RECEIVED
JUL 1 1953
FBI - KNOX
TERRY & DEER
1035 ELYSIUM LN
FORESTVILLE, MD 21053
ALCOHOL FROM LABORATORY
ANALYSIS

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Page 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with the form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

10441

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10450

1. DECEASED-NAME (Type or Print) <i>Johnathan First Middle Last Jonathon Reid Fauntleroy</i>						2a. DATE KNOWN <input checked="" type="checkbox"/> OF ESTI-DEATH MATED <input type="checkbox"/> <i>7</i> Month <i>9</i> Day <i>1968</i> Year			2b. HOUR <i>3:00</i> a M		
3. SEX <i>M</i>	4. RACE <i>W</i>	5. DATE OF BIRTH <i>21 Jan., 1953</i> 15 YRS.	6. AGE (in years lost birthday) <i>15</i>	IF UNDER 1 YEAR MONTHS <i>15</i> DAYS <i>15</i>	IF UNDER 24 HRS. HOURS <i>15</i> MIN <i>15</i>	2c. DATE PRONOUNCED DEAD Month <i>7</i> Day <i>9</i> Year <i>68</i>			2d. HOUR <i>Same</i>		
7a. BIRTHPLACE (State or foreign country) <i>California</i>		7b. CITIZEN OF WHAT COUNTRY? <i>USA</i>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <i>Prince George</i> Md.					
10. CITY OR TOWN OF DEATH <i>Forestville</i>			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>Andrews Air Force Hosp.</i>			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <i>Student</i>			12b. KIND OF BUSINESS OR INDUSTRY <i>School</i>		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <i>Md</i>			13b. COUNTY <i>Baltimore</i>		13c. CITY OR TOWN <i>Baltimore</i>	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET AND NUMBER <i>703 Anneslie Rd.</i>				
14. FATHER'S NAME First Middle Last <i>William Reid Fauntleroy</i>				15. MOTHER'S MAIDEN NAME First Middle Last <i>Beirdre Ann Holdsworth</i>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>			16b. SOCIAL SECURITY NO. (If yes give war or dates of service) <i>219-56-2700</i>		17. INFORMANT ADDRESS <i>Mother Same as above</i>						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Intoxication</i> <i>7509</i> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <i>Colchicine</i> (b) <i>2 days</i> DUE TO, OR AS A CONSEQUENCE OF (c)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <i>9718</i>											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>			21b. TIME OF INJURY Month, Day, Year <i>7:99 P.M. 7 7 1968</i>			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) <i>Drank solution of colchicine</i>					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>			21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) <i>Edgemoor School</i>			21f. LOCATION Street or R.F.D. No. <i>Rt 301</i>		City or Town <i>Clinton</i>		County <i>P.G.</i> State <i>Md.</i>	
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE <i>John Kehoe</i>			EXAMINER'S NAME (Type) <i>John Kehoe, M.D., Riverdale, Md.</i>			CHIEF MEDICAL EXAMINER <input type="checkbox"/>			22b. DATE SIGNED <i>7-9-68</i>		
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>			23b. DATE <i>July 11, 1968</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Baltimore National Cem.</i>			23d. LOCATION (City or Town) <i>Catonsville, Maryland</i>		(County) (State)	
24. FUNERAL DIRECTOR <i>John Burns' Sons, Towson, Maryland</i>						25a. REC'D BY REGISTRAR <i>JUL 15 1968</i>			25b. REGISTRAR'S SIGNATURE <i>J Charles Judge</i>		



RECEIVED
JAN 11 1951
U.S. DEPARTMENT OF HEALTH
BUREAU OF PUBLIC HEALTH
DIVISION OF VETERINARY MEDICINE
WASHINGTON, D.C.

PATIENT INFORMATION		MEDICAL HISTORY		PHYSICAL EXAMINATION		LABORATORY TESTS		TREATMENT		REMARKS	
NAME	John Doe	AGE	35	SEX	Male	RACE	White	RELIGION	Protestant	EDUCATION	High School
DATE OF BIRTH	1916	DATE OF ADMISSION	1951	DATE OF DISCHARGE		DATE OF DEATH		DATE OF AUTOPSY		DATE OF REVISION	
ROOM	101	WARD	10	CLINIC	10	LABORATORY	10	TREATMENT	10	REMARKS	
History of Present Illness: Patient admitted to hospital on 1/11/51 with complaint of fever, chills, and sweats. Physical examination on admission showed temperature 101.0 F, pulse 100, respirations 20, blood pressure 120/80. Laboratory tests showed leukocytes 15,000, hemoglobin 12.0, hematocrit 35.0. Treatment with penicillin and aspirin resulted in improvement. Discharged on 1/15/51.											
Physical Examination: On admission, patient appeared ill. Temperature 101.0 F, pulse 100, respirations 20, blood pressure 120/80. On 1/12/51, temperature 100.5 F, pulse 90, respirations 18, blood pressure 110/70. On 1/13/51, temperature 100.0 F, pulse 80, respirations 16, blood pressure 100/60. On 1/14/51, temperature 99.5 F, pulse 70, respirations 14, blood pressure 90/50. On 1/15/51, temperature 99.0 F, pulse 60, respirations 12, blood pressure 80/40.											
Laboratory Tests: On admission, leukocytes 15,000, hemoglobin 12.0, hematocrit 35.0. On 1/12/51, leukocytes 10,000, hemoglobin 12.0, hematocrit 35.0. On 1/13/51, leukocytes 8,000, hemoglobin 12.0, hematocrit 35.0. On 1/14/51, leukocytes 6,000, hemoglobin 12.0, hematocrit 35.0. On 1/15/51, leukocytes 4,000, hemoglobin 12.0, hematocrit 35.0.											
Treatment: Patient received penicillin 100,000 units daily and aspirin 650 mg every 4 hours. Discharged on 1/15/51.											
Remarks: Patient improved and discharged on 1/15/51.											

CERTIFICATE OF DEATH

10442

10451

1. DECEASED-NAME (Type or print) Queenie A. FERGUSON		First		Middle		Last		2a. DATE OF DEATH Month JULY Day 10 Year 1968			2b. HOUR 9:45 P.M.	
3. SEX F		4. RACE NE GRO		5. DATE OF BIRTH SEPT 12, 1893			6. AGE (In years last birthday) 84 YRS.		IF UNDER 1 YEAR MONTHS 8 DAYS 4		IF UNDER 24 HRS. HOURS 9 MIN 45	
7a. BIRTHPLACE (State or foreign country) S. CAROLINA		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH PRINCE GEORGE'S Md.						
10. CITY OR TOWN OF DEATH Hyattsville		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) HYATTSVILLE NURSING HOME; 6500 RIGGS RD.			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)			12b. KIND OF BUSINESS OR INDUSTRY				
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE D.C.		13b. COUNTY WASHINGTON		13c. CITY OR TOWN WASHINGTON		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 3930 16th ST NE NW 1.				
14. FATHER'S NAME First Middle Last		15. MOTHER'S MAIDEN NAME First Middle Last										
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown		16b. SOCIAL SECURITY NO. (If yes give war or dates of service)		17. INFORMANT Address								
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) RESPIRATORY ARREST - ASPIRATION 150X DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 150X (b) CARCINOMA OF THE ESOPHAGOUS DUE TO, OR AS A CONSEQUENCE OF (c)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH mins mos.		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) LAENERS CIRRHOSIS, CARDIOMEGALY, PULM. EMBOLISM.												
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)								
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No.		City or Town		County		State		
22a. I certify that (I) (this hospital) attended the deceased from JULY 8, 1968 , to JULY 10, 1968 , that (I) (we) last saw the deceased alive on JULY 9, 1968 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.												
22b. SIGNATURE Harold W. Draper M.D.		DEGREE		ATTENDING PHYS. <input checked="" type="checkbox"/>		MED. DIRECTOR <input type="checkbox"/>		STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED July 10, 68		
22d. PHYSICIAN'S NAME (Type) HAROLD W. DRAPER M.D.		22e. ADDRESS 9801 GEORGIA AVE.		22f. SIGNATURE William Spangler								
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE 7/14/1968		23c. NAME OF CEMETERY OR CREMATORY SOAP STONE CHURCH CEMETERY		23d. LOCATION (City or Town) GREENVILLE		(County)		(State) S.Car		
24. FUNERAL DIRECTOR William Spangler		ADDRESS WASH D.C.		25a. REC'D BY REGISTRAR JUL 15 1968		25b. REGISTRAR'S SIGNATURE Charles J. J...						

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

10:12

UNITED STATES OF AMERICA

FRANCIS

MI

U.S. 100

UNITED STATES OF AMERICA

FRANCIS

10:12

U.S. 100

UNITED STATES OF AMERICA

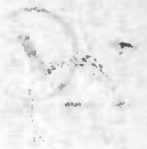
FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
Item 5, 6, 8 Film 403 8 MEDICAL EXAMINER'S CERTIFICATE OF DEATH									
1. DECEASED-NAME (Type or Print)			First Middle Last			20. DATE KNOWN OF ESTI- DEATH MATED <input checked="" type="checkbox"/> Month Day Year			2b. HOUR
Adeline			Bonn			Fickus			19 6:00pm
3. SEX	4. RACE	5. DATE OF BIRTH		6. AGE (If under 1 year, give months and days)	IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN	2c. DATE PRONOUNCED DEAD Month Day Year		2d. HOUR
Female	White	29 March 1895		63 yrs.			7 20 68		7:30pm M
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH			
Scranton, Penn.		U. S. A.				Prince George's Md.			
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)				12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY	
Hyattsville		Hyattsville Nursing Home				Housewife		OWN Home	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission). STATE				13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
Maryland				Prince George's		Lanham		9324 Alcona Street	
14. FATHER'S NAME First Middle Last			15. MOTHER'S MAIDEN NAME First Middle Last						
Adam L. Bonn			Henrietta Schumacher						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16b. SOCIAL SECURITY NO.		17. INFORMANT				
No			yes		3924 Alcona Street Mrs. Adelaide Jones Lanham, Maryland				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Malignant glioma, right temporal</u> 1929 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH over 6 mo.
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 1929									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No.		City or Town		County State	
22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>									
ACTUAL SIGNATURE EXAMINER'S NAME (Type)			22b. DATE SIGNED						
John Kehoe MD Riverdale, Md.			7-21-68						
23a. BURIAL, CREMATION, REMOVAL (Specify)			23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)		
Burial			July 23, 1968		Dunmore Cemetery		Dunmore, Pennsylvania		
24. FUNERAL DIRECTOR			25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE				
Warner E. Pumphrey, Inc.			JUL 26 1968		Charles Judge				

FOR STATE
HEALTH DEPT.



RECEIVED
JAN 10 1901
STATE HEALTH DEPT.

101 2-25-01

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										
CERTIFICATE OF DEATH										
1. DECEASED-NAME (Type or print) CATHERINE Katherine			Middle Last E. Fischer			2a. DATE OF DEATH Month Day Year July 22, 1968		2b. HOUR 1:55 AM		
3. SEX Female		4. RACE Caucasian		5. DATE OF BIRTH 12/9/1881		6. AGE (In years last birthday) 87 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.		
7a. BIRTHPLACE (State or foreign country) DC		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Prince George's Md.				
10. CITY OR TOWN OF DEATH Cheverly			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Prince Geo. Gen. Hosp.			12a. USUAL OCCUPATION (Kind of work done during most of life, even if retired.) Mr and wife		12b. KIND OF BUSINESS OR INDUSTRY		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland			13b. COUNTY Prince Geo.		13c. CITY OR TOWN Seat Pleasant		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 600 Addison Road	
14. FATHER'S NAME First Middle Last Oliver J. Preston			15. MOTHER'S MAIDEN NAME First Middle Last Margaret Shugroo							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown <input checked="" type="checkbox"/> (If yes give war or dates of service)			16b. SOCIAL SECURITY NO. 579017404		17. INFORMANT (Son) Address Oliver Fischer, 6807 Randolph St, Landover, Md.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Severe obstructive jaundice 1570 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. Pen Carcinoma of the head of the pancreas DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 157X Arterio-sclerosis heart disease										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) did not attended the deceased from 7/13/68 , 19 68 , to July 22 , 19 68 , that (I) was last saw the deceased alive on July 21 , 19 68 , and that in (my) own opinion death occurred on the date and hour and from the causes stated above, (I) was (did) view the body after death.										
22b. SIGNATURE Elie A. Sayan MD					DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED 7/24/68			
22d. PHYSICIAN'S NAME (Type) ELIE A. SAYAN					22e. ADDRESS 5803 Landover Rd Chevy Chase, Md					
23a. BURIAL, CREMATION, REMOVAL (Specify) Buried		23b. DATE 7-25-68		23c. NAME OF CEMETERY OR CREMATORY Glennwood Cemetery			23d. LOCATION (City or Town) (County) (State) Washington, D.C.			
24. FUNERAL DIRECTOR Wilhelm Funerals Home Switzland, MARYLAND					25a. REC'D BY REGISTRAR DATE JUL 29 1968		25b. REGISTRAR'S SIGNATURE J. Charles Judge			

1888

STATE OF OHIO

County of _____

IN SENATE

January 1888

Resolved, That

the sum of _____

be and the same is hereby

appropriated to the _____

of the _____

for the _____

of the _____

of the _____

of the _____

of the _____

of the _____

of the _____

of the _____

of the _____

of the _____

of the _____

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death.
Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. The funeral director should remove carbon papers, page 4 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MEDICAL CERTIFICATION

10443										DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										10454									
1. DECEASED-NAME (Type or print) <i>Malcolm Francis Freshman</i>										2a. DATE OF DEATH Month <i>7</i> Day <i>27</i> Year <i>1968</i>										2b. HOUR <i>9:25</i> M									
3. SEX <i>Male</i>					4. RACE <i>white</i>					5. DATE OF BIRTH <i>Sept 18, 1915</i>					6. AGE (In years last birthday) <i>52</i> YRS.					IF UNDER 1 YEAR MONTHS DAYS					IF UNDER 24 HRS. HOURS MIN.				
7a. BIRTHPLACE (State or foreign country) <i>Md</i>					7b. CITIZEN OF WHAT COUNTRY? <i>US A</i>					8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>					9. COUNTY OF DEATH <i>Prince George's</i> Md.														
10. CITY OR TOWN OF DEATH <i>Lanham, Md</i>					11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>6302-93th ave</i>					12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <i>Fuel oil dealer</i>					12b. KIND OF BUSINESS OR INDUSTRY <i>self</i>														
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <i>Md</i>					13b. COUNTY <i>Pro Georges</i>					13c. CITY OR TOWN <i>Lanham</i>					13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					13e. STREET AND NUMBER <i>6302 93th avenue</i>									
14. FATHER'S NAME First <i>Francis</i> Middle <i>Levi</i> Last <i>Freshman</i>										15. MOTHER'S MAIDEN NAME First <i>Rose</i> Middle <i>R</i> Last <i>Simpson</i>																			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown <i>no</i> (If yes give war or dates of service)					16b. SOCIAL SECURITY NO. <i>217 01 6009</i>					17. INFORMANT <i>Mabel I Freshman</i>					Address <i>Lanham, Md.</i>														
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Carcinomatous</i> <i>1621</i> DUE TO, OR AS A CONSEQUENCE OF <i>Cancer Right Lung</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>1 year</i> (c)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>Several months</i>																			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a) <i>163X</i>																													
19a. DATE OF OPERATION					19b. CONDITION FOR WHICH OPERATION WAS PERFORMED					20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?														
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)					21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <i>19</i>					21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)																			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>					21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)					21f. LOCATION Street or R.F.D. No. City or Town County State																			
22a. I certify that (I) (this hospital) attended the deceased from <i>June</i> , 1967, to <i>7/27</i> , 1968, that (I) (was) last saw the deceased alive on <i>7/27</i> , 1968, and that in (my) (my) opinion death occurred on the date and hour and from the causes stated above, (I) (was) (did) (did not) view the body after death.																													
22b. SIGNATURE <i>James Kurtz MD</i>					DEGREE <i>MD</i>					ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>					22c. DATE SIGNED <i>7/27/68</i>														
22d. PHYSICIAN'S NAME (Type) <i>Dr James Kurtz</i>					22e. ADDRESS <i>R.F.D. Glenn Dale Md</i>																								
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>					23b. DATE <i>July 30, 1968</i>					23c. NAME OF CEMETERY OR CREMATORY <i>Ft Lincoln Cemetery</i>					23d. LOCATION (City or Town) (County) (State) <i>Colmar Manor Pro Geo Md.</i>														
24. FUNERAL DIRECTOR <i>F. Gasch's Sons</i>					ADDRESS <i>Hyattsville, Md.</i>					25a. REC'D BY REGISTRAR <i>AUG 1 1968</i>					25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>														

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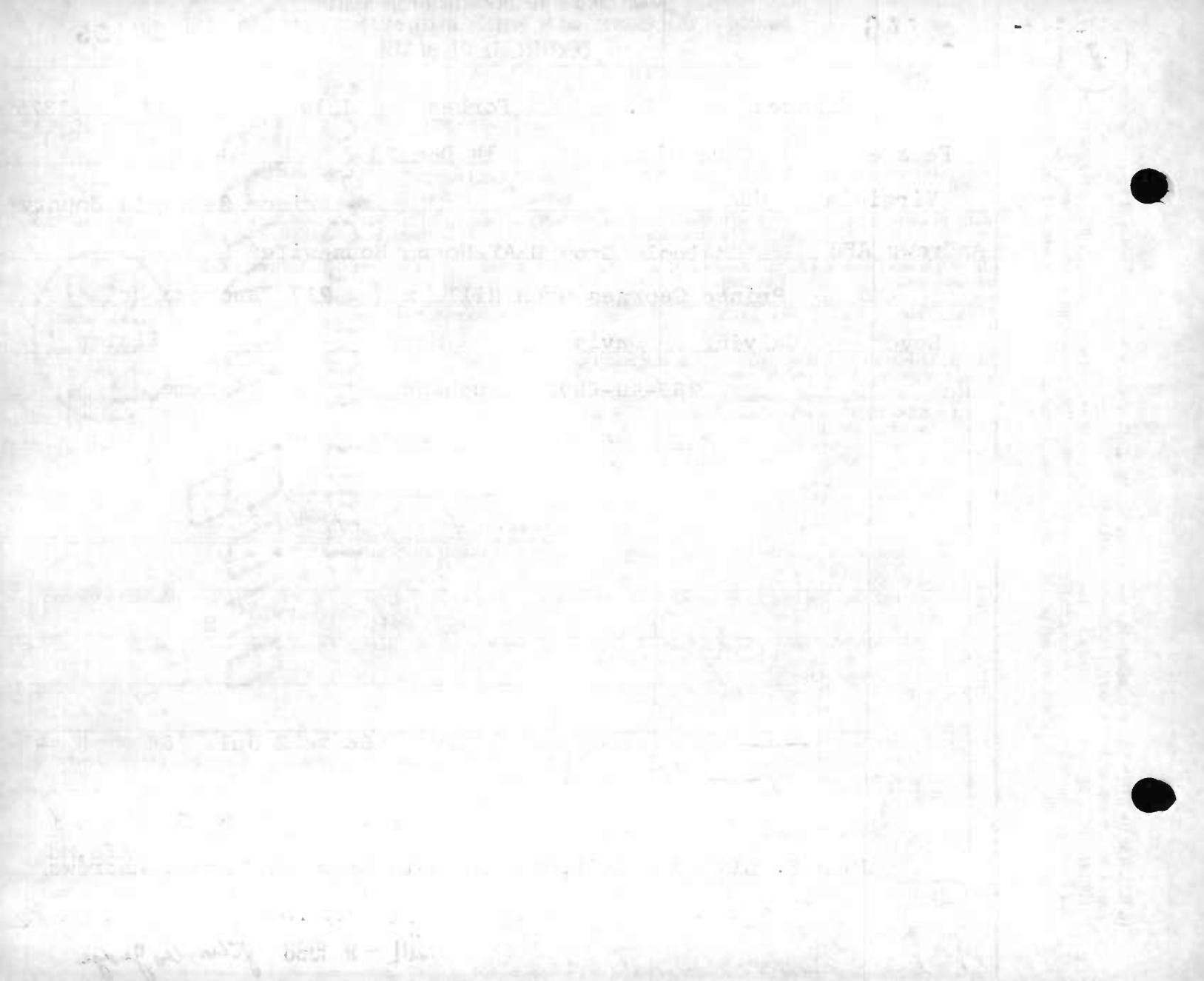
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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2, should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
CERTIFICATE OF DEATH									
1. DECEASED-NAME (Type or print) First Middle Last Frances D. Forbes					2a. DATE OF DEATH Month Day Year July 2 68			2b. HOUR 1325M	
3. SEX Female		4. RACE Caucasian		5. DATE OF BIRTH 14 Dec 23		6. AGE (In years last birthday) 44 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (State or foreign country) Virginia		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Prince George's County Md.			
10. CITY OR TOWN OF DEATH Andrews AFB		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Malcolm Grow USAF Hosp		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Housewife		12b. KIND OF BUSINESS OR INDUSTRY			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Md		13b. COUNTY Prince Georges		13c. CITY OR TOWN Oxon Hill		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 217 Panorama Dr	
14. FATHER'S NAME First Middle Last Lloyd Calvin Davis		15. MOTHER'S MAIDEN NAME First Middle Last Mary Slater							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) No		(If yes give war or dates of service)		16b. SOCIAL SECURITY NO. 263-40-6002		17. INFORMANT Husband		Address Same	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Broncho pneumonia, septicemia, pyelonephritis</u> 174x DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Cerebra</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Metastatic Brain Tumor, 10 @ Breast.</u>									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) 170x									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? No		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY Hour A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No.		City or Town		County State	
22a. I certify that (I) (this hospital) attended the deceased from <u>1 May</u> , 19 <u>68</u> , to <u>2 Jul</u> , 19 <u>68</u> , that (I) (we) last saw the deceased alive on <u>2 Jul</u> , 19 <u>68</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <u>John F. Lindeman</u>		DEGREE		ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22c. DATE SIGNED <u>2 Jul 68</u>			
22d. PHYSICIAN'S NAME (Type) JOHN F. LINDEMAN, CAPT, USAF		22e. ADDRESS Malcolm Grow USAF Hosp, Andrews AFB, Md							
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE 7/5/68		23c. NAME OF CEMETERY OR CREMATORY Tabernacle Mem. Cem		23d. LOCATION (City or Town) (County) (State) New Kent County Va			
24. FUNERAL DIRECTOR <u>W. Chambers Co</u>		ADDRESS 1400 Chapin St		25a. REC'D BY REGISTRAR JUL - 9 1968		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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10447

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

10456

1. DECEASED-NAME (Type or print) First Middle Last Rose S. Forkish			2a. DATE OF DEATH Month Day Year 7 23 68		2b. HOUR 7:30 A M
3. SEX Female		4. RACE White	5. DATE OF BIRTH 12/8/05		6. AGE (In years last birthday) 62 YRS.
7a. BIRTHPLACE (State or foreign country) New York		7b. CITIZEN OF WHAT COUNTRY? U S A	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Prince George's Md.
10. CITY OR TOWN OF DEATH Cheverly		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Prince George's Gen. Hosp.		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Housewife	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland		13b. COUNTY Prince Geo.	13c. CITY OR TOWN Bowie	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET AND NUMBER 12400 Ryland Ct.
14. FATHER'S NAME First Middle Last Kalman Ferster			15. MOTHER'S MAIDEN NAME First Middle Last Ida Gross		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) no (If yes give war or dates of service)		16b. SOCIAL SECURITY NO.		17. INFORMANT Address Max Flrkish Bowie, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary Embolus 4109 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 4201 (b) Myocardial infarction DUE TO, OR AS A CONSEQUENCE OF (c) Arteriosclerotic Cardiovascular disease					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a) Diabetes Mellitus Cognitive Decline					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1b.)	
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State	
22a. I certify that (I) (this hospital) attended the deceased from June 16, 1968 , to July 23, 1968 , that (I) (we) last saw the deceased alive on 23 July 1968 , and that in my (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE Robert Deitz, M.D.		22c. DATE SIGNED 7/22/68		22d. PHYSICIAN'S NAME (Type) Robert Deitz, M.D.	
22e. ADDRESS Prince George's Plaza, Hyattsville, Md.		22f. ADDRESS Prince George's Plaza, Hyattsville, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE July 25, 1968		23c. NAME OF CEMETERY OR CREMATORY Ft Lincoln Cemetery	
23d. LOCATION (City or Town) (County) (State) Colmar Manor Pro Geo Md.		23e. LOCATION (City or Town) (County) (State) Colmar Manor Pro Geo Md.			
24. FUNERAL DIRECTOR P. Gasch's Sons Hyattsville, Md.		25a. REC'D BY REGISTRAR DATE JUL 26 1968		25b. REGISTRAR'S SIGNATURE J. Charles Judge	

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1995, 1996, 1997, 1998, 1999, 2000, 2001, 2002, 2003, 2004, 2005, 2006, 2007, 2008, 2009, 2010, 2011, 2012, 2013, 2014, 2015, 2016, 2017, 2018, 2019, 2020, 2021, 2022, 2023, 2024, 2025, 2026, 2027, 2028, 2029, 2030, 2031, 2032, 2033, 2034, 2035, 2036, 2037, 2038, 2039, 2040, 2041, 2042, 2043, 2044, 2045, 2046, 2047, 2048, 2049, 2050, 2051, 2052, 2053, 2054, 2055, 2056, 2057, 2058, 2059, 2060, 2061, 2062, 2063, 2064, 2065, 2066, 2067, 2068, 2069, 2070, 2071, 2072, 2073, 2074, 2075, 2076, 2077, 2078, 2079, 2080, 2081, 2082, 2083, 2084, 2085, 2086, 2087, 2088, 2089, 2090, 2091, 2092, 2093, 2094, 2095, 2096, 2097, 2098, 2099, 2100, 2101, 2102, 2103, 2104, 2105, 2106, 2107, 2108, 2109, 2110, 2111, 2112, 2113, 2114, 2115, 2116, 2117, 2118, 2119, 2120, 2121, 2122, 2123, 2124, 2125, 2126, 2127, 2128, 2129, 2130, 2131, 2132, 2133, 2134, 2135, 2136, 2137, 2138, 2139, 2140, 2141, 2142, 2143, 2144, 2145, 2146, 2147, 2148, 2149, 2150, 2151, 2152, 2153, 2154, 2155, 2156, 2157, 2158, 2159, 2160, 2161, 2162, 2163, 2164, 2165, 2166, 2167, 2168, 2169, 2170, 2171, 2172, 2173, 2174, 2175, 2176, 2177, 2178, 2179, 2180, 2181, 2182, 2183, 2184, 2185, 2186, 2187, 2188, 2189, 2190, 2191, 2192, 2193, 2194, 2195, 2196, 2197, 2198, 2199, 2200, 2201, 2202, 2203, 2204, 2205, 2206, 2207, 2208, 2209, 2210, 2211, 2212, 2213, 2214, 2215, 2216, 2217, 2218, 2219, 2220, 2221, 2222, 2223, 2224, 2225, 2226, 2227, 2228, 2229, 2230, 2231, 2232, 2233, 2234, 2235, 2236, 2237, 2238, 2239, 2240, 2241, 2242, 2243, 2244, 2245, 2246, 2247, 2248, 2249, 2250, 2251, 2252, 2253, 2254, 2255, 2256, 2257, 2258, 2259, 2260, 2261, 2262, 2263, 2264, 2265, 2266, 2267, 2268, 2269, 2270, 2271, 2272, 2273, 2274, 2275, 2276, 2277, 2278, 2279, 2280, 2281, 2282, 2283, 2284, 2285, 2286, 2287, 2288, 2289, 2290, 2291, 2292, 2293, 2294, 2295, 2296, 2297, 2298, 2299, 2300, 2301, 2302, 2303, 2304, 2305, 2306, 2307, 2308, 2309, 2310, 2311, 2312, 2313, 2314, 2315, 2316, 2317, 2318, 2319, 2320, 2321, 2322, 2323, 2324, 2325, 2326, 2327, 2328, 2329, 2330, 2331, 2332, 2333, 2334, 2335, 2336, 2337, 2338, 2339, 2340, 2341, 2342, 2343, 2344, 2345, 2346, 2347, 2348, 2349, 2350, 2351, 2352, 2353, 2354, 2355, 2356, 2357, 2358, 2359, 2360, 2361, 2362, 2363, 2364, 2365, 2366, 2367, 2368, 2369, 2370, 2371, 2372, 2373, 2374, 2375, 2376, 2377, 2378, 2379, 2380, 2381, 2382, 2383, 2384, 2385, 2386, 2387, 2388, 2389, 2390, 2391, 2392, 2393, 2394, 2395, 2396, 2397, 2398, 2399, 2400, 2401, 2402, 2403, 2404, 2405, 2406, 2407, 2408, 2409, 2410, 2411, 2412, 2413, 2414, 2415, 2416, 2417, 2418, 2419, 2420, 2421, 2422, 2423, 2424, 2425, 2426, 2427, 2428, 2429, 2430, 2431, 2432, 2433, 2434, 2435, 2436, 2437, 2438, 2439, 2440, 2441, 2442, 2443, 2444, 2445, 2446, 2447, 2448, 2449, 2450, 2451, 2452, 2453, 2454, 2455, 2456, 2457, 2458, 2459, 2460, 2461, 2462, 2463, 2464, 2465, 2466, 2467, 2468, 2469, 2470, 2471, 2472, 2473, 2474, 2475, 2476, 2477, 2478, 2479, 2480, 2481, 2482, 2483, 2484, 2485, 2486, 2487, 2488, 2489, 2490, 2491, 2492, 2493, 2494, 2495, 2496, 2497, 2498, 2499, 2500, 2501, 2502, 2503, 2504, 2505, 2506, 2507, 2508, 2509, 2510, 2511, 2512, 2513, 2514, 2515, 2516, 2517, 2518, 2519, 2520, 2521, 2522, 2523, 2524, 2525, 2526, 2527, 2528, 2529, 2530, 2531, 2532, 2533, 2534, 2535, 2536, 2537, 2538, 2539, 2540, 2541, 2542, 2543, 2544, 2545, 2546, 2547, 2548, 2549, 2550, 2551, 2552, 2553, 2554, 2555, 2556, 2557, 2558, 2559, 2560, 2561, 2562, 2563, 2564, 2565, 2566, 2567, 2568, 2569, 2570, 2571, 2572, 2573, 2574, 2575, 2576, 2577, 2578, 2579, 2580, 2581, 2582, 2583, 2584, 2585, 2586, 2587, 2588, 2589, 2590, 2591, 2592, 2593, 2594, 2595, 2596, 2597, 2598, 2599, 2600, 2601, 2602, 2603, 2604, 2605, 2606, 2607, 2608, 2609, 2610, 2611, 2612, 2613, 2614, 2615, 2616, 2617, 2618, 2619, 2620, 2621, 2622, 2623, 2624, 2625, 2626, 2627, 2628, 2629, 2630, 2631, 2632, 2633, 2634, 2635, 2636, 2637, 2638, 2639, 2640, 2641, 2642, 2643, 2644, 2645, 2646, 2647, 2648, 2649, 2650, 2651, 2652, 2653, 2654, 2655, 2656, 2657, 2658, 2659, 2660, 2661, 2662, 2663, 2664, 2665, 2666, 2667, 2668, 2669, 2670, 2671, 2672, 2673, 2674, 2675, 2676, 26

1. 2. 3.

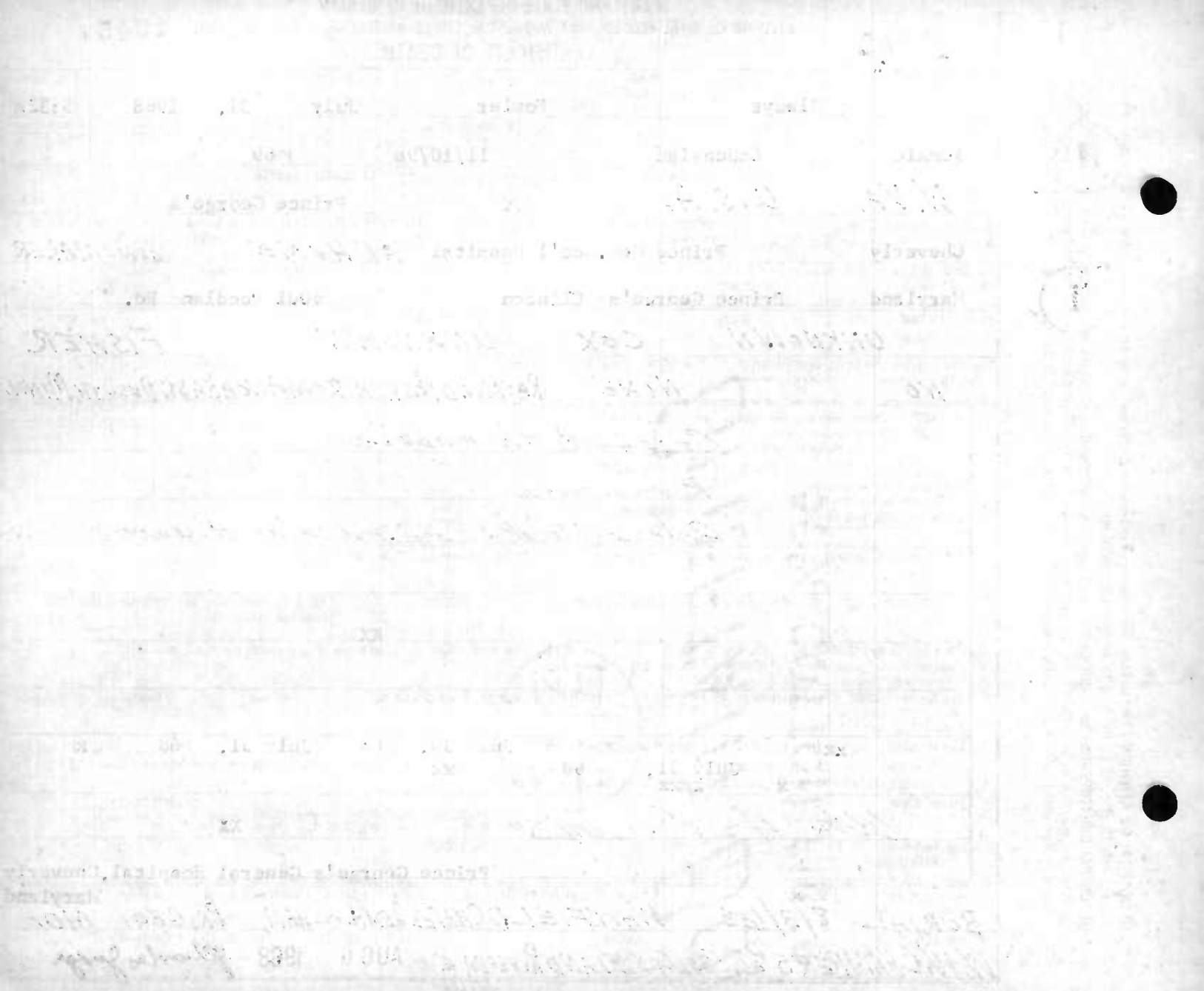
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VR A15 (4)
30M REV. 1/68

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
10448									
CERTIFICATE OF DEATH									
1. DECEASED-NAME (Type or print)			First Middle Last			2a. DATE OF DEATH Month Day Year			2b. HOUR
Gladys			Fowler			July 31, 1968			5:32 AM
3. SEX		4. RACE		5. DATE OF BIRTH			6. AGE (In years last birthday)		IF UNDER 1 YEAR MONTHS DAYS
Female		Caucasian		11/10/98			69 YRS.		IF UNDER 24 HRS. HOURS MIN.
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH			
W. VA.		U.S.A.				Prince George's Md.			
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)			12b. KIND OF BUSINESS OR INDUSTRY
Cheverly			Prince Geo. Gen'l Hospital			AT HOME			HOMEMAKER
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) - STATE			13b. COUNTY			13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
Maryland			Prince George's			Clinton		6001 Woodland Rd.	
14. FATHER'S NAME First Middle Last			15. MOTHER'S MAIDEN NAME First Middle Last						
UNKNOWN COX			UNKNOWN FISHER						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16b. SOCIAL SECURITY NO.		17. INFORMANT Address				
NO			NONE		RAYMOND POST, JR. 204 W. ANOAK ST. DULUTH, MINN.				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral thrombosis</u> 4129 DUE TO, OR AS A CONSEQUENCE OF (b) <u>Pneumonia</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Arteriosclerotic cardiovascular disease</u>									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 4221									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that xx (this hospital) attended the deceased from <u>July 30, 1968</u> , to <u>July 31, 1968</u> , that he (we) last saw the deceased alive on <u>July 31, 1968</u> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above, he (we) (did not) view the body after death.									
22b. SIGNATURE <u>W. W. Chambers, M.D.</u>					22c. DATE SIGNED				
22d. PHYSICIAN'S NAME (Type)					22e. ADDRESS				
					Prince George's General Hospital, Cheverly				
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County)		23e. STATE	
BURIAL		8/3/68		WHITFIELD CHAPEL CEM.		LANHAM PR. GEO.		MD.	
24. FUNERAL DIRECTOR					25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE		
W.W. CHAMBERS 60, 5801 CLEVELAND RIVERDALE					DATE AUG 6 1968		J. Charles Judge		

MEDICAL CERTIFICATION



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers - Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

10449

10458

1. DECEASED-NAME (Type or print)			First	Middle	Last	2a. DATE OF DEATH			2b. HOUR		
Allen			S.		Freeze	July 5, 1968			7:40 p M		
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)		IF UNDER 1 YEAR		IF UNDER 24 HRS.	
Male		White		02-01-08		60 YRS.		MONTHS		DAYS	
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH					
West Virginia		U.S.A.				Prince Georges Md.					
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)			12b. KIND OF BUSINESS OR INDUSTRY		
Cheverly			Prince George Hospt.			Repairman			C&P Telephone		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE			13b. COUNTY			13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET AND NUMBER	
Maryland			Pr. Geo.			Cheverly		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		6215 Forrest Road	
14. FATHER'S NAME			First	Middle	Last	15. MOTHER'S MAIDEN NAME			First	Middle	Last
Willis					Freeze	Bessie					Yountz
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes give war or dates of service)			16b. SOCIAL SECURITY NO.			17. INFORMANT					
No			577-01-0099			Catherine C. Freeze - 6215 Forrest Road					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY:											
IMMEDIATE CAUSE (a) <i>Carcinoma of Esophagus</i>											
DUE TO, OR AS A CONSEQUENCE OF											
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.											
DUE TO, OR AS A CONSEQUENCE OF											
(b)											
(c)											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (o)											
<i>150X Esophagus branched fistula</i>											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
						YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY			21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.)					
			HOUR A.M. Month Day Year P.M. 19								
21d. INJURY OCCURRED			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION			Street or R.F.D. No. City or Town County State		
While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>											
22a. I certify that (I) (this hospital) attended the deceased from <i>April</i> , 1968, to <i>July 5</i> , 1968, that (I) (we) last saw the deceased alive on <i>July 5 1968</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE						DEGREE		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED	
<i>George William Ware</i>										7-6-68	
22d. PHYSICIAN'S NAME (Type)						22e. ADDRESS					
George William Ware						1835 - I - St., N.W., Washington, D.C.					
23a. BURIAL, CREMATION, REMOVAL (Specify)			23b. DATE			23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION (City or Town) (County) (State)		
Burial			7-8-68			Resurrection Cemetery			Clinton, Pr. Geo., Maryland		
24. FUNERAL DIRECTOR						ADDRESS			25a. REC'D BY REGISTRAR		
F. Gasch & Sons, Hyattsville, Maryland									25b. REGISTRAR'S SIGNATURE		
						DATE			<i>J Charles Judge</i>		
						JUL - 8 1968					

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FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PMS-1. 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

Item 22a 11m 403
8-5-68 mt DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10459

1. DECEASED-NAME (Type or Print)		First		Middle		Last		2a. DATE KNOWN OF ESTI- DEATH MATED <input checked="" type="checkbox"/> 7-21-68 194:34pmm		2b. HOUR	
Timothy		Joseph		Frye Jr.							
3. SEX	4. RACE	5. DATE OF BIRTH		6. AGE (In years last birthday)		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN.		2c. DATE PRONOUNCED DEAD Month 7 Day 21 Year 68 197:00pm M	
Male	White	2-22-1926		42 YRS.							
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. COUNTY OF DEATH				Md.	
Washington D C		U S A				Prince George's					
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY					
Cheverly		Prince George Hospital		Machinist		Newspaper					
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) - STATE		13b. CITY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER			
Maryland		Prince George's		Hyattsville				5407 38th. Avenue			
14. FATHER'S NAME		First		Middle		Last		15. MOTHER'S MAIDEN NAME		First Middle Last	
Timothy		Joseph		Frye Sr				Dorothy C Mc Gill			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		(If yes give war or dates of service)		16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS			
yes		W W 11		577 28 9296		Timothy J Frye sr		Hyattsville, Md.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Laceration of brain</u> <u>929X</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a). stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <u>9368</u>											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY Month, Day, Year HOUR A.M. <u>4:34pm</u> 7-21- 19 68				21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) Unknown			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>				21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) B & O Railroad Tracks,				21f. LOCATION Street or R.F.D. No. City or Town County State Emerson Street, Hyattsville, Prince George Co.,			
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE <u>John Kehoe</u> M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>				22b. DATE SIGNED 7-22-68			
EXAMINER'S NAME (Type) John Kehoe MD				Riverville, Md.				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> ADDRESS (Street, city, town, or county)			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE July 25, 1968		23c. NAME OF CEMETERY OR CREMATORY Ft Lincoln Cemetery		23d. LOCATION (City or Town) (County) (State) Colmar Manor Pro Geo Md.					
24. FUNERAL DIRECTOR F. Gasch's Sons				ADDRESS Hyattsville, Md.				25a. REC'D BY REGISTRAR DATE JUL 26 1968		25b. REGISTRAR'S SIGNATURE Charles Judge	

10453

NEW YORK STATE DEPARTMENT OF HEALTH

TECHNICAL EXAMINER'S CERTIFICATE OF QUALIFICATION

10453

10453

NAME	John J. Smith
RESIDENCE	123 Main Street, New York, N.Y.
EDUCATION	High School Graduate
EXPERIENCE	5 years as a technical examiner
RECOMMENDATION	Recommended by the Board of Health
DATE	July 1, 1953

Location of Exam

TEST RESULTS	Pass
REMARKS	Good knowledge of the subject
SIGNATURE	[Signature]
DATE	July 1, 1953

10453 JUL 2 1953

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										
10451										
CERTIFICATE OF DEATH										
10460										
1. DECEASED-NAME (Type or print)			First Middle Last			2a. DATE OF DEATH Month Day Year			2b. HOUR	
Bernard			J. Fuller			July 16 1968			1:50 am	
3. SEX		4. RACE		5. DATE OF BIRTH			6. AGE (In years last birthday)		IF UNDER 1 YEAR MONTHS DAYS	
male		White		April 27, 1902			66 YRS.			
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH			
Germany		U.S.A.					Prince George's Md.			
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)			12b. KIND OF BUSINESS OR INDUSTRY	
Riverdale			Eugene Leland Memorial Hosp.							
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE			13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER	
Maryland			Pr. Geo.		Greenbelt				6 Lake Crest Dr.	
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME							
First Middle Last			First Middle Last							
Johann J. Fuller			Adelheit Jansen-							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown)			16b. SOCIAL SECURITY NO.		17. INFORMANT Address					
			579-10-9001		E. Leland Mem. Hosp. 4408 Queensbury Rd.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Intestinal Hemorrhage</u> 1519 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>TOTAL GASTRECTOMY</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>CARCINOMA OF STOMACH</u>									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 hr	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) 151X Uremia + wound infection										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
7-2-68		TOTAL GASTRECTOMY			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State					
					6-26, 1968, to 7-15, 1968					
22a. I certify that (I) (this hospital) attended the deceased from <u>6-26</u> , 19 <u>68</u> , to <u>7-15</u> , 19 <u>68</u> , that (I) (we) last saw the deceased alive on <u>7-15</u> , 19 <u>68</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE <u>R. F. Wilkinson</u>					DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED <u>7-16-68</u>			
22d. PHYSICIAN'S NAME (Type) <u>R. F. WILKINSON MD</u>					22e. ADDRESS <u>Riverdale, Md.</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION (City or Town) (County) (State)			
Burial		July 19, 1968		Gate of Heaven Cemetery			Wheaton Montgomery Md.			
24. FUNERAL DIRECTOR ADDRESS					25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE			
F. Gasch's Sons Hyattsville, Md.					JUL 19 1968		<u>J. Charles Judge</u>			

IN WITNESS WHEREOF

I, the undersigned, County Clerk of said County,

have hereunto set my hand and the seal of said County,

this 10th day of May, 1900.

Attest my hand and the seal of said County,

this 10th day of May, 1900.

W. H. HARRIS, County Clerk.

By my hand and the seal of said County,

this 10th day of May, 1900.

Attest my hand and the seal of said County,

this 10th day of May, 1900.

W. H. HARRIS, County Clerk.

By my hand and the seal of said County,

this 10th day of May, 1900.

Attest my hand and the seal of said County,

this 10th day of May, 1900.

W. H. HARRIS, County Clerk.

**FOR STATE
HEALTH DEPT.**

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form P-103. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										
10452 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 10461										
1. DECEASED-NAME (Type or Print) First Middle Last Anita Dolores Galloway						2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> Month Day Year 7-26-68 192:30pm		2b. HOUR		
3. SEX Female		4. RACE White		5. DATE OF BIRTH 5-28-1968		6. AGE (In years last birthday) MONTHS DAYS HOURS MIN. YRS. 1 28		2c. DATE PRONOUNCED DEAD Month Day Year 7 26 68 192:30pm		
7a. BIRTHPLACE (State or foreign country) Maryland		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Prince George's Md.				
10. CITY OR TOWN OF DEATH Clinton			11. NAME OF HOSPITAL OR INSTITUTION (if not in hospital give street address) Clinton Medical Center			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Infant		12b. KIND OF BUSINESS OR INDUSTRY		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland			13b. COUNTY Prince George's		13c. CITY OR TOWN Clinton		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 7815 Surrats Road	
14. FATHER'S NAME First Middle Last Jake W. Galloway Sr.					15. MOTHER'S MAIDEN NAME First Middle Last Rose Briggs					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO			16b. SOCIAL SECURITY NO. NONE		17. INFORMANT (Father) ADDRESS Jake W. Galloway Sr, Same as #13					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute peritonitis 567.9 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 576X										
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>			21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)			21f. LOCATION Street or R.F.D. No. City or Town County State				
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>										
ACTUAL SIGNATURE John Kehoe MD			EXAMINER'S NAME (Type) John Kehoe MD Riverdale, Md.			CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			22b. DATE SIGNED 7-27-68	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial			23b. DATE 7-30-68		23c. NAME OF CEMETERY OR CREMATORY Fort Lincoln Cemetery			23d. LOCATION (City or Town) (County) (State) PG County, Maryland		
24. FUNERAL DIRECTOR Wilhelm Funeral Home 4308 Suitland Rd. SE, Suitland, Maryland						25a. REC'D BY REGISTRAR AUG 1 1968		25b. REGISTRAR'S SIGNATURE J Charles Judge		

TOP SECRET
HEALTH DEPT

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1. NAME		2. GRADE		3. POSITION		4. DIVISION		5. REPORTING OFFICER	
6. DATE		7. TIME		8. LOCATION		9. SUBJECT		10. COMMENTS	
11. SIGNATURE		12. INITIALS		13. DATE		14. TIME		15. LOCATION	
16. SIGNATURE		17. INITIALS		18. DATE		19. TIME		20. LOCATION	
21. SIGNATURE		22. INITIALS		23. DATE		24. TIME		25. LOCATION	
26. SIGNATURE		27. INITIALS		28. DATE		29. TIME		30. LOCATION	
31. SIGNATURE		32. INITIALS		33. DATE		34. TIME		35. LOCATION	
36. SIGNATURE		37. INITIALS		38. DATE		39. TIME		40. LOCATION	
41. SIGNATURE		42. INITIALS		43. DATE		44. TIME		45. LOCATION	
46. SIGNATURE		47. INITIALS		48. DATE		49. TIME		50. LOCATION	
51. SIGNATURE		52. INITIALS		53. DATE		54. TIME		55. LOCATION	
56. SIGNATURE		57. INITIALS		58. DATE		59. TIME		60. LOCATION	
61. SIGNATURE		62. INITIALS		63. DATE		64. TIME		65. LOCATION	
66. SIGNATURE		67. INITIALS		68. DATE		69. TIME		70. LOCATION	
71. SIGNATURE		72. INITIALS		73. DATE		74. TIME		75. LOCATION	
76. SIGNATURE		77. INITIALS		78. DATE		79. TIME		80. LOCATION	
81. SIGNATURE		82. INITIALS		83. DATE		84. TIME		85. LOCATION	
86. SIGNATURE		87. INITIALS		88. DATE		89. TIME		90. LOCATION	
91. SIGNATURE		92. INITIALS		93. DATE		94. TIME		95. LOCATION	
96. SIGNATURE		97. INITIALS		98. DATE		99. TIME		100. LOCATION	

AUG 1 1964

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon copies of pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 Item 5 & 7 Film 10453 10462									
1. DECEASED-NAME (Type or print) Cyphers Garrison					2a. DATE OF DEATH Month July , Day 29 , Year 1968			2b. HOUR 1:30PM	
3. SEX Female		4. RACE Negro		5. DATE OF BIRTH 5/9/94 1905		6. AGE (In years last birthday) 63 YRS.		IF UNDER 1 YEAR MONTHS IF UNDER 24 HRS. DAYS HOURS MIN.	
7a. BIRTHPLACE (State or foreign country) Tennessee		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Prince George's Md.			
10. CITY OR TOWN OF DEATH Cheverly		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Prince Geo.Gen'l Hospital		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)			12b. KIND OF BUSINESS OR INDUSTRY		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland		13b. COUNTY Prince George's		13c. CITY OR TOWN Cedar Hgts.		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 6230 Lee Place	
14. FATHER'S NAME First Middle Last			15. MOTHER'S MAIDEN NAME First Middle Last						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) (If yes give war or dates of service)			16b. SOCIAL SECURITY NO.		17. INFORMANT Address				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Irreversible shock DUE TO, OR AS A CONSEQUENCE OF (b) Acute Gastric Dilatation DUE TO, OR AS A CONSEQUENCE OF (c) Post-op status from Intest. obst. 5609 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 5705									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No.		City or Town		County State	
22a. I certify that (this hospital) attended the deceased from July 20, 1968 , to July 29, 1968 , that (we) last saw the deceased alive on July 29, 1968 , and that in (our) opinion death occurred on the date and hour and from the causes stated above. (we) (did) (did not) view the body after death.									
22b. SIGNATURE R. Longoria DEGREE					ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22c. DATE SIGNED 7-30-68		
22d. PHYSICIAN'S NAME (Type) Ricardo Longoria, M. D.					22e. ADDRESS Prince George's General Hospital, Cheverly,				
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE 8-11-68		23c. NAME OF CEMETERY OR CREMATORY Clarksville		23d. LOCATION (City or Town) (County) Clarksville Tenn		23e. RECORDS SECTION 357	
24. FUNERAL DIRECTOR Oscar Bamer ADDRESS #19-15th St SE					25a. REC'D BY REGISTRAR 1968		25b. RECORDS SECTION 357		

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARTLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
1. DECEASED-NAME (Type or print)		First	Middle	Lost	2a. DATE OF DEATH Month Day Year			2b. HOUR	
Patrick		Leo	Gilmore		July 22 1968			11:20 AM	
3. SEX	4. RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.
Male	White		2/18/1900		68				
7a. BIRTHPLACE (State or foreign country)	7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH				
W. Virginia	U.S.A.				Prince Georges Md.				
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b. KIND OF BUSINESS OR INDUSTRY				
Glenn Dale	Glenn Dale Hospital		retired - unknown		unknown				
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE	13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER		
Washington			Wash., D. C.				1536 17th St. N. W.		
14. FATHER'S NAME	First	Middle	Lost	15. MOTHER'S MAIDEN NAME		First	Middle	Lost	
Patrick	J.	Gilmore		Nora		A.	Fallon		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown)		16b. SOCIAL SECURITY NO.		17. INFORMANT Address					
no		227-14-2546		Decedent					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Spontaneous pneumothorax, left DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a). stating the underlying cause lost. 5277 (b) massive bilateral pulmonary emphysema DUE TO, OR AS A CONSEQUENCE OF (c) PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) Pulmonary tuberculosis, moderately advanced, active (5 yrs., 11 mos.); generalized arteriosclerosis.									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 30 min.
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? yes			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (this hospital) attended the deceased from 7/12/1967, to 7/22/1968, that (we) last saw the deceased alive on 7/22/1968, and that in (our) opinion death occurred on the date and hour and from the causes stated above, (we) (did) (did not) view the body after death.									
22b. SIGNATURE Moe Weiss				DEGREE ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED 7/22/1968			
22d. PHYSICIAN'S NAME (Type) Moe Weiss, M. D.				22e. ADDRESS Glenn Dale Hospital Glenn Dale, Maryland					
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)			
burial		7/25/68		Cedar Hill Cemetery		Covington, Virginia			
24. FUNERAL DIRECTOR The S.H. Kim Co.				ADDRESS 2901 14th St. NW. D.C.		25a. REC'D BY REGISTRAR DATE JUL 25 1968		25b. REGISTRAR'S SIGNATURE Charles Judge	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or print) John W. Glascoe			2a. DATE OF DEATH Month July Day 2 Year 1968			2b. HOUR 5:30 A.M.					
3. SEX Male		4. RACE White		5. DATE OF BIRTH October 11, 1890		6. AGE (In years lost birthday) 77 3/4 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.			
7a. BIRTHPLACE (State or foreign country) D.C.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Prince Georges			Md.		
10. CITY OR TOWN OF DEATH Glenn Dale (rural)		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Glenn Dale Hospital		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Unknown - retired		12b. KIND OF BUSINESS OR INDUSTRY Unknown					
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE D.C.		13b. COUNTY Washington		13c. CITY OR TOWN Washington		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 2840 Bladensburg Road, N.E.			
14. FATHER'S NAME Unknown John W. Glascoe Sr		15. MOTHER'S MAIDEN NAME Unknown Martha Booth									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16b. SOCIAL SECURITY NO. 579-07-6865		17. INFORMANT (Decedent)							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary embolism 011.9 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 002.1 (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) Pulmonary tuberculosis 1 yr. 1 mo.								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH sudden			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) Generalized arteriosclerosis											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State							
22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from 6/14/ , 19 67 , to 7/2/ , 19 68 , that <input checked="" type="checkbox"/> (we) lost saw the deceased alive on 7/2/ , 19 68 , and that in <input checked="" type="checkbox"/> (my) (our) opinion death occurred on the date and hour and from the causes stated above, <input checked="" type="checkbox"/> (we) (did) not view the body after death.											
22b. SIGNATURE Moe Weiss		22c. DATE SIGNED July 2, 1968		22d. PHYSICIAN'S NAME (Type) Moe Weiss, M.D.		22e. ADDRESS Glenn Dale Hospital Glenn Dale, Maryland					
23a. BURIAL CREMATION, REMOVAL (Specify) Burial		23b. DATE July 5, 1968		23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery		23d. LOCATION (City or Town) (County) (State) Bladensburg Md.					
24. FUNERAL DIRECTOR Simmons Bros.		ADDRESS 1661 Good Hope Rd. S.E. WASH. D.C.		25a. REC'D BY REGISTRAR JUL - 5 1968		25b. REGISTRAR'S SIGNATURE Charles Judge					

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October 1950
Glenn Dale, Maryland

Glenn Dale (Army) - 1950

Glenn Dale (Army) - 1950

Glenn Dale, Maryland
Glenn Dale Hospital

Glenn Dale, D.D.

JUL - 5 1950

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

Item 22a Film 404
6-24-68 ams DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

10465

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MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or Print) Andrew			2a. DATE KNOWN OF ESTI-DEATH MATED <input checked="" type="checkbox"/> 7-30-68			2b. HOUR 198:34pm		
3. SEX Male	4. RACE White	5. DATE OF BIRTH 11-30-1941	6. AGE (In years last birthday) 26 YRS.	IF UNDER 1 YEAR MONTHS 7	IF UNDER 24 HRS DAYS 30	2c. DATE PRONOUNCED DEAD Month 7	2d. HOUR Day 30	Year 68
7a. BIRTHPLACE (State or foreign country) Greece		7b. CITIZEN OF WHAT COUNTRY? Greece		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Prince George's		
10. CITY OR TOWN OF DEATH Riverdale		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Ieland Memorial Hospital		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Resturant Owner		12b. KIND OF BUSINESS OR INDUSTRY Resturant		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland		13b. COUNTY Prince George's		13c. CITY OR TOWN Riverdale		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 5309 Riverdale Rd., #625
14. FATHER'S NAME First Lois			Middle Glinos			Last Unk		
15. MOTHER'S MAIDEN NAME First Lois			Middle Glinos			Last Unk		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No			16b. SOCIAL SECURITY NO. (If yes give war or dates of service) None			17. INFORMANT Lois Glinos Father		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Gun shot wound of chest 965X DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 981X								
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?			20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY Month, Day, Year HOUR A.M. 6:37pm 7-30-19 68			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) -		
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK			21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) Home			21f. LOCATION Street or R.F.D. No. City or Town County State Same as # 13		
22a. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input checked="" type="checkbox"/> , Undetermined monner <input type="checkbox"/>								
ACTUAL SIGNATURE EXAMINER'S NAME (Type) John Kehoe MD			M.D. Riverdale, Md.			22b. DATE SIGNED 7-31-68		
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial			23b. DATE 8/5/1968			23c. NAME OF CEMETERY OR CREMATORY Ft Lincoln Cemetery		
24. FUNERAL DIRECTOR Nalley's Funeral Home			ADDRESS Mt. Rainier, Md.			25a. REC'D BY REGISTRAR DATE AUG 7 1968		
25b. REGISTRAR'S SIGNATURE Charles Judge								

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers: Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
30M REV. 1/68

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										10466	
1. DECEASED-NAME (Type or print)					2a. DATE OF DEATH		2b. HOUR				
First Middle Last Betty A. Goetz					Month Day Year July 6 68		9:45 M				
3. SEX Female		4. RACE Caucasian		5. DATE OF BIRTH 21 Oct 27		6. AGE (In years lost birthday) 40 YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (State or foreign country) Wash., D.C.		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Prince George's County Md.					
10. CITY OR TOWN OF DEATH Andrews AFB			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Malcomb Grow USAF Hosp.			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Housewife			12b. KIND OF BUSINESS OR INDUSTRY		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Md.			13b. COUNTY Prince George		13c. CITY OR TOWN Oxon Hill		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER 7309 Oxon Hill Rd.		
14. FATHER'S NAME First Middle Last Carol Amiss			15. MOTHER'S MAIDEN NAME First Middle Last Mabyl Hanback								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No			16b. SOCIAL SECURITY NO.		17. INFORMANT Address Col. Robert T. Goetz 7309 Oxon Hill Rd. Md.						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Anoxia DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Recurrent Bronchogenic Ca. DUE TO, OR AS A CONSEQUENCE OF (c)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 24 hr. 1 yr.	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) 1621											
19a. DATE OF OPERATION 1621		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED Ca of lung				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1B.)							
21d. INJURY OCCURRED While <input type="checkbox"/> Nat while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No.		City or Town		County		State	
22a. I certify that (I) (this hospital) attended the deceased from Sept 19 67 , to 6 July 68 , that (I) (we) last saw the deceased alive on 5 July 19 67 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE Frank A. Camp										22c. DATE SIGNED 6 July 68	
22d. PHYSICIAN'S NAME (Type) Frank A. Camp M.D.					22e. ADDRESS Malcolm Grow USAF Hospital Andrews AFB, Wash., D.C. 20331						
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 7/8/68		23c. NAME OF CEMETERY OR CREMATORY Cedar Hill			23d. LOCATION (City or Town) (County) (State) Suitland, Md				
24. FUNERAL DIRECTOR Lee Funeral Home Washington, D. C.					25a. REC'D BY REGISTRAR JUL 10 1968		25b. REGISTRAR'S SIGNATURE J. Charles Judge				

1999, 2000, 2001, 2002, 2003, 2004, 2005, 2006, 2007, 2008, 2009, 2010, 2011, 2012, 2013, 2014, 2015, 2016, 2017, 2018, 2019, 2020, 2021, 2022, 2023, 2024, 2025, 2026, 2027, 2028, 2029, 2030, 2031, 2032, 2033, 2034, 2035, 2036, 2037, 2038, 2039, 2040, 2041, 2042, 2043, 2044, 2045, 2046, 2047, 2048, 2049, 2050, 2051, 2052, 2053, 2054, 2055, 2056, 2057, 2058, 2059, 2060, 2061, 2062, 2063, 2064, 2065, 2066, 2067, 2068, 2069, 2070, 2071, 2072, 2073, 2074, 2075, 2076, 2077, 2078, 2079, 2080, 2081, 2082, 2083, 2084, 2085, 2086, 2087, 2088, 2089, 2090, 2091, 2092, 2093, 2094, 2095, 2096, 2097, 2098, 2099, 2100, 2101, 2102, 2103, 2104, 2105, 2106, 2107, 2108, 2109, 2110, 2111, 2112, 2113, 2114, 2115, 2116, 2117, 2118, 2119, 2120, 2121, 2122, 2123, 2124, 2125, 2126, 2127, 2128, 2129, 2130, 2131, 2132, 2133, 2134, 2135, 2136, 2137, 2138, 2139, 2140, 2141, 2142, 2143, 2144, 2145, 2146, 2147, 2148, 2149, 2150, 2151, 2152, 2153, 2154, 2155, 2156, 2157, 2158, 2159, 2160, 2161, 2162, 2163, 2164, 2165, 2166, 2167, 2168, 2169, 2170, 2171, 2172, 2173, 2174, 2175, 2176, 2177, 2178, 2179, 2180, 2181, 2182, 2183, 2184, 2185, 2186, 2187, 2188, 2189, 2190, 2191, 2192, 2193, 2194, 2195, 2196, 2197, 2198, 2199, 2200, 2201, 2202, 2203, 2204, 2205, 2206, 2207, 2208, 2209, 2210, 2211, 2212, 2213, 2214, 2215, 2216, 2217, 2218, 2219, 2220, 2221, 2222, 2223, 2224, 2225, 2226, 2227, 2228, 2229, 2230, 2231, 2232, 2233, 2234, 2235, 2236, 2237, 2238, 2239, 2240, 2241, 2242, 2243, 2244, 2245, 2246, 2247, 2248, 2249, 2250, 2251, 2252, 2253, 2254, 2255, 2256, 2257, 2258, 2259, 2260, 2261, 2262, 2263, 2264, 2265, 2266, 2267, 2268, 2269, 2270, 2271, 2272, 2273, 2274, 2275, 2276, 2277, 2278, 2279, 2280, 2281, 2282, 2283, 2284, 2285, 2286, 2287, 2288, 2289, 2290, 2291, 2292, 2293, 2294, 2295, 2296, 2297, 2298, 2299, 2300, 2301, 2302, 2303, 2304, 2305, 2306, 2307, 2308, 2309, 2310, 2311, 2312, 2313, 2314, 2315, 2316, 2317, 2318, 2319, 2320, 2321, 2322, 2323, 2324, 2325, 2326, 2327, 2328, 2329, 2330, 2331, 2332, 2333, 2334, 2335, 2336, 2337, 2338, 2339, 2340, 2341, 2342, 2343, 2344, 2345, 2346, 2347, 2348, 2349, 2350, 2351, 2352, 2353, 2354, 2355, 2356, 2357, 2358, 2359, 2360, 2361, 2362, 2363, 2364, 2365, 2366, 2367, 2368, 2369, 2370, 2371, 2372, 2373, 2374, 2375, 2376, 2377, 2378, 2379, 2380, 2381, 2382, 2383, 2384, 2385, 2386, 2387, 2388, 2389, 2390, 2391, 2392, 2393, 2394, 2395, 2396, 2397, 2398, 2399, 2400, 2401, 2402, 2403, 2404, 2405, 2406, 2407, 2408, 2409, 2410, 2411, 2412, 2413, 2414, 2415, 2416, 2417, 2418, 2419, 2420, 2421, 2422, 2423, 2424, 2425, 2426, 2427, 2428, 2429, 2430, 2431, 2432, 2433, 2434, 2435, 2436, 2437, 2438, 2439, 2440, 2441, 2442, 2443, 2444, 2445, 2446, 2447, 2448, 2449, 2450, 2451, 2452, 2453, 2454, 2455, 2456, 2457, 2458, 2459, 2460, 2461, 2462, 2463, 2464, 2465, 2466, 2467, 2468, 2469, 2470, 2471, 2472, 2473, 2474, 2475, 2476, 2477, 2478, 2479, 2480, 2481, 2482, 2483, 2484, 2485, 2486, 2487, 2488, 2489, 2490, 2491, 2492, 2493, 2494, 2495, 2496, 2497, 2498, 2499, 2500, 2501, 2502, 2503, 2504, 2505, 2506, 2507, 2508, 2509, 2510, 2511, 2512, 2513, 2514, 2515, 2516, 2517, 2518, 2519, 2520, 2521, 2522, 2523, 2524, 2525, 2526, 2527, 2528, 2529, 2530, 2531, 2532, 2533, 2534, 2535, 2536, 2537, 2538, 2539, 2540, 2541, 2542, 2543, 2544, 2545, 2546, 2547, 2548, 2549, 2550, 2551, 2552, 2553, 2554, 2555, 2556, 2557, 2558, 2559, 2560, 2561, 2562, 2563, 2564, 2565, 2566, 2567, 2568, 2569, 2570, 2571, 2572, 2573, 2574, 2575, 2576, 2577, 2578, 2579, 2580, 2581, 2582, 2583, 2584, 2585, 2586, 2587, 2588, 2589, 2590, 2591, 2592, 2593, 2594, 2595, 2596, 2597, 2598, 2599, 2600, 2601, 2602, 2603, 2604, 2605, 2606, 2607, 2608, 2609, 2610, 2611, 2612, 2613, 2614, 2615, 2616, 2617, 2618, 2619, 2620, 2621, 2622, 2623, 2624, 2625, 2626, 2627, 2628, 2629, 2630, 2631, 2632, 2633, 2634, 2635, 2636, 2637, 2638, 2639, 2640, 2641, 2642, 2643, 2644, 2645, 2646, 2647, 2648, 2649, 2650, 2651, 2652, 2653, 2654, 2655, 2656, 2657, 2658, 2659, 2660, 2661, 2662, 2663, 2664, 2665, 2666, 2667, 2668, 2669, 2670, 2671, 2672, 2673, 2674, 2675, 2676, 2677, 2678, 2679, 2680, 26

55-10-16

112

1076

Lat: 40.217096, Lon: -100.134

Journal of Management Education 30(6)

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FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

10458

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10467

1. DECEASED-NAME (Type or Print)			First Middle Last			20. DATE KNOWN OF DEATH			2b. HOUR		
Alex Robert Grieshamer						Month Day Year			19 10:00pm		
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (In years last birthday)	IF UNDER 1 YEAR		IF UNDER 24 HRS.		2c. DATE PRONOUNCED DEAD			2d. HOUR
Male	White	7-21-1891	77 YRS.	MONTHS	DAYS	HOURS	MIN	Month Day Year	19 1:05am M		
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH					
Illinois		U S A				Prince George's Md.					
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)			12b. KIND OF BUSINESS OR INDUSTRY		
Cheverly			Prince George Hospital			Mechanic			U S Government		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE			13b. COUNTY			13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET AND NUMBER	
Maryland			Prince George's			Bowie		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		3006 Bendix Lane	
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME								
Charles R Grieshamer			Margaret Dixon								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16b. SOCIAL SECURITY NO.			17. INFORMANT			ADDRESS		
no			579 52 1331			Edward Grieshamer			Bowie, Md.		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 1. DEATH WAS CAUSED BY:											
IMMEDIATE CAUSE (a) Gun shot wound of head											
955 X DUE TO, OR AS A CONSEQUENCE OF											
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.											
(b) DUE TO, OR AS A CONSEQUENCE OF											
(c) DUE TO, OR AS A CONSEQUENCE OF											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)											
976 X											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY?			
								YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/>				21b. TIME OF INJURY Month, Day, Year				21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
CAUSE OF DEATH				10:00pm 7-21-19 68				Shot self with .32 cal. automatic pistol			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>				21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)				21f. LOCATION Street or R.F.D. No. City or Town County State			
				Home				Same as # 13			
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE				CHIEF MEDICAL EXAMINER <input type="checkbox"/>				22b. DATE SIGNED			
EXAMINER'S NAME (Type)				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>				7-23-68			
John Kehoe MD				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>				ADDRESS (Street, city, town, or county)			
Riverdale, Md.											
23a. BURIAL, CREMATION, REMOVAL (Specify)			23b. DATE		23c. NAME OF CEMETERY OR REMOVAL			23d. LOCATION (City or Town) (County) (State)			
Burial			July 24, 1968		George Washington			Hyattsville Pro Geo Md.			
24. FUNERAL DIRECTOR						25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE			
F. Gasch's Sons Hyattsville, Md.						JUL 26 1968		Charles Judge			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH															
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201															
CERTIFICATE OF DEATH															
1. DECEASED-NAME (Type or print)				First Middle Last				2a. DATE OF DEATH				2b. HOUR			
Ernest				William				Griggs				July 21 1968		2,55AM	
3. SEX		4. RACE		5. DATE OF BIRTH				6. AGE (In years last birthday)		IF UNDER 1 YEAR		IF UNDER 24 HRS.			
Male		White		9 Oct., 1915				52 YRS.		MONTHS DAYS		HOURS MIN.			
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH									
Washington D C		U S A.				Pr. Geo., Md.									
10. CITY OR TOWN OF DEATH				11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)				12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)				12b. KIND OF BUSINESS OR INDUSTRY			
Cheverly				Pr. Geo. Gen Hosp.,				Retired roofer				self			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE				13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER					
Maryland				Pr. Geo.,		Hillside				1307 57th Avenue.,					
14. FATHER'S NAME First Middle Last				15. MOTHER'S MAIDEN NAME First Middle Last											
John A Griggs				Mamie O Harbin											
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes give war or dates of service)				16b. SOCIAL SECURITY NO.		17. INFORMANT Address									
Yes, no, or unknown				577 09 6359		Ernest W Griggs Jr Washington D. C.									
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
PART 1. DEATH WAS CAUSED BY:															
IMMEDIATE CAUSE (a) <u>cardiac arrest due to atherosclerosis</u>												1 hr			
DUE TO, OR AS A CONSEQUENCE OF (b) <u>ischemic heart disease</u>												6 hr			
DUE TO, OR AS A CONSEQUENCE OF (c) <u>coronary heart disease</u>												4 day			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)															
4200															
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)				21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19				21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)				21f. LOCATION Street or R.F.D. No. City or Town County State							
22a. I certify that (I) (this hospital) attended the deceased from July 16, 1968, to July 21, 1968, that (I) (we) last saw the deceased alive on July 21, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.															
22b. SIGNATURE												22c. DATE SIGNED			
T Bergman												July 21/68			
22d. PHYSICIAN'S NAME (Type)												22e. ADDRESS			
												Greenbelt, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify)				23b. DATE		23c. NAME OF CEMETERY OR CREMATORY				23d. LOCATION (City or Town) (County) (State)					
Burial				7/23/68		Ft Lincoln Cemetery				Colmar Manor Pro Geo Md.					
24. FUNERAL DIRECTOR						25a. REC'D BY REGISTRAR				25b. REGISTRAR'S SIGNATURE					
F Gasch's Sons Hyattsville, Md.						DATE JUL 25 1968				Charles Judge					

100



100

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
CERTIFICATE OF DEATH									
1. DECEASED-NAME (Type or print)			First	Middle	Last	2a. DATE OF DEATH Month Day Year			2b. HOUR
Irene			E		Hanglitter	July 1 1968			2,45AM
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)		IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.
Female		White		15 Nov., 1895		72 YRS.			
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH			
New Jersey		U.S.A.				Prinee Georges Md.			
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY	
Cheverly			Pr. Geo. Gen. Hosp.,			Ret. U.S. Govt.			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE			13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER
Maryland			Pr., Geo.		Hyattsville				2502 Queens Chapel Rd.
14. FATHER'S NAME			First	Middle	Last	15. MOTHER'S MAIDEN NAME			First Middle Last
Edward			R.		Hanglitter	Elina J.			Krow
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown			16b. SOCIAL SECURITY NO.		17. INFORMANT		Address		
no			217-52-8044		T Dorothy V. Hanglitter		(above address)		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral thrombosis, pontine</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Cerebral arteriosclerosis</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u></u>									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) <u>Diverterculosis - hemorrhagic; arteriosclerotic heart disease - myocardial infarction</u>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
6/27/68		Diverterculosis - Hemorrhagic			YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		Yes		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)				
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State				
22a. I certify that (I) (this hospital) attended the deceased from 6/15, 1968, to 7/1, 1968, that (I) (we) last saw the deceased alive on 6/30, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE					DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE/SIGNED		
Jerome Sandler, M. D.							7/1/68		
22d. PHYSICIAN'S NAME (Type)					22e. ADDRESS				
					1726 Eye St., NW, Washington, D.C.				
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)			
Burial		7/3/68		Wash. Natl. Cem.		Suitland Pr. Geo. Md.			
24. FUNERAL DIRECTOR					25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE		
Valley's Funeral Home, Inc.					JUL 10 1968		Charles Judge		

1963

1963

(M)

STATE OF TEXAS
COUNTY OF DALLAS

Know all men to these presents, that I, James Earl Ray, of the County of Dallas, State of Texas, for and in consideration of the sum of One Hundred Dollars to me in hand paid by John Edgar Hoover, the receipt of which is hereby acknowledged, have granted, sold and conveyed, and by these presents do grant, sell and convey unto the said John Edgar Hoover, his heirs and assigns forever, all that certain lot or lots of land situated in the County of Dallas, State of Texas, to wit: Lot 1, Block 1, Subdivision 1, of the Dallas County Jail Site, Dallas County, Texas.

Witness my hand and seal of office this 10th day of July, 1963, at Dallas, Texas.

James Earl Ray
Notary Public in and for the State of Texas

My Comm. Expires July 10, 1965

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
CERTIFICATE OF DEATH									
1. DECEASED-NAME (Type or print)			First Middle Last			2a. DATE OF DEATH			2b. HOUR
MARY			HANLY			Month Day Year			9:05 M
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)		IF UNDER 1 YEAR	
F		WHITE		8-9-94		43 YRS.		MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED		9. COUNTY OF DEATH		Md.	
Pa.		U.S.		WIDOWED		Prince George			
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b. KIND OF BUSINESS OR INDUSTRY			
Lanham		Magnolia Gardens Home		Housewife					
13a. USUAL RESIDENCE (Where deceased lived, if institution, residence before admission) STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET AND NUMBER	
Md.		P.G.		Brentwood		YES NO		4506 39th St.	
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME						
First Middle Last			First Middle Last						
Unknown			Unknown						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes, no, or unknown)			16b. SOCIAL SECURITY NO.			17. INFORMANT			
No						S.G. Kist General Home, Pa.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 1. DEATH CAUSED BY:									
IMMEDIATE CAUSE (a) Bronchopneumonia bilateral								5 days	
DUE TO, OR AS A CONSEQUENCE OF									
(b) Cerebral Thrombosis								7 days	
DUE TO, OR AS A CONSEQUENCE OF									
(c) Cerebral Arteriosclerosis								2 yrs	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)									
332X Diabetes Mellitus									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
					YES NO				
21a. ACCIDENT WAS UNDERLYING		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
<input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		HOUR A.M. Month Day Year							
		P.M. 19							
21d. INJURY OCCURRED		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION		Street or R.F.D. No.		City or Town County State	
While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work									
22a. I certify that (I) (this hospital) attended the deceased from 8/31, 1968, to 7/2, 1968, that (I) (we) last saw the deceased alive on 7/2, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE		22c. DATE SIGNED							
Norman J. Donat		7/2/68							
22d. PHYSICIAN'S NAME (Type)		22e. ADDRESS							
Norman J. Donat		3503 Penny St. Mt Rainier Md.							
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)			
Burial		7-5-68		Calvary Cemetery		Altoona, Pa.			
24. FUNERAL DIRECTOR		ADDRESS		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE			
Valley Funeral Home		Mt. Rainier Md.		JUL 10 1968		Charles Judge			

10-1-11

LETTER OF CREDIT

20

11

Payable to order of
Cash
Five hundred dollars

NOT TO BE CASHED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 and file them with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										
<div style="display: flex; justify-content: space-between;"> 10462 CERTIFICATE OF DEATH 10471 </div>										
1. DECEASED-NAME (Type or print) First Middle Last Florence E. Hardesty					2a. DATE OF DEATH Month 9 , Day 9 , Year 1968			2b. HOUR 9:05AM		
3. SEX Female		4. RACE Caucasian		5. DATE OF BIRTH March 19, 1888		6. AGE (In years last birthday) 80 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.		
7a. BIRTHPLACE (State or foreign country) Maryland		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Prince George's Md.				
10. CITY OR TOWN OF DEATH Cheverly			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Prince Geo. Gen'l Hospital			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Housewife		12b. KIND OF BUSINESS OR INDUSTRY Home		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland			13b. COUNTY Prince George's		13c. CITY OR TOWN Cheverly		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 2802 63rd Place	
14. FATHER'S NAME First Middle Last Benjamin Dare					15. MOTHER'S MAIDEN NAME First Middle Last Alice Smith					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) No (If yes give war or dates of service)			16b. SOCIAL SECURITY NO. Unknown		17. INFORMANT (son) Hyattsville, Maryland Bernard H Hardesty Jr. 4709 68 Ave					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac Tamponade. 4109 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Ruptured myocardial infarct. DUE TO, OR AS A CONSEQUENCE OF (c) Coronary arteriosclerotic heart disease.									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 4201										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (the hospital) attended the deceased from 1947 to July 9, 1968 , that (I) (was) last saw the deceased alive on July 9, 1968 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (do not) view the body after death.										
22b. SIGNATURE <i>Julius Kauffman, MD</i>					ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED 7/9/68			
22d. PHYSICIAN'S NAME (Type) Julius Kauffman, M. D.					22e. ADDRESS 6501 Landover Rd., Cheverly, Md. 20785					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 7-12-68		23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery			23d. LOCATION (City or Town) (County) (State) Suitland, Maryland			
24. FUNERAL DIRECTOR Wilhelm Funeral Home ADDRESS 4308 Suitland Rd. SE, Suitland, Maryland					25a. REC'D BY REGISTRAR JUL 15 1968		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>			

1. The first step is to identify the problem or question that needs to be answered. This involves understanding the context and the specific information required.

10. 11. 2007. 11:24

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or print) First CLARA Middle B. Last HART			2a. DATE OF DEATH 7 Month 5 Day 68 Year		2b. HOUR M
3. SEX FEMALE	4. RACE Negro	5. DATE OF BIRTH 9/8/98		6. AGE (In years last birthday) 69 YRS.	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.
7a. BIRTHPLACE (State or foreign country) AMISSVILLE, VA.	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH Prince George Md.		
10. CITY OR TOWN OF DEATH Hyattsville, Md.	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) CARROLL MANOR 4922 KASLOVE Rd.		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) HOUSEWIFE	12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE D. C.	13b. COUNTY WASH. D.C.	13c. CITY OR TOWN WASH. D.C.	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	13e. STREET AND NUMBER 308 EMERSON ST. N.W.	
14. FATHER'S NAME First WALTER Middle SMITH Last		15. MOTHER'S MAIDEN NAME First LAURA Middle DAVENPORT Last			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown NO		16b. SOCIAL SECURITY NO. 579-16-69448B		17. INFORMANT SE. M. CATHERINE Bernavette Address CARROLL MANOR 4922 KASLOVE Rd.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4129 Cardiac and respiratory arrest DUE TO, OR AS A CONSEQUENCE OF (b) Arteriosclerotic heart disease DUE TO, OR AS A CONSEQUENCE OF (c) Cerebral arteriosclerosis					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH —
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) 4200 Parkinson's disease					
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)		
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State		
22a. I certify that (I) (this hospital) attended the deceased from 7/5 , 19 68 , to 7/5 , 19 68 , that (I) (we) last saw the deceased alive on 7/5 , 19 68 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE Joseph A. Romeo MD DEGREE			ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22c. DATE SIGNED 7/5/68	
22d. PHYSICIAN'S NAME (Type) Joseph A. Romeo M.D.			22e. ADDRESS 4731 Mass. Ave. Washington, D.C.		
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE 7-9-68	23c. NAME OF CEMETERY OR CREMATORY Harmony Memorial Park		23d. LOCATION (City or Town) (County) (State) Prince George, Md.	
24. FUNERAL DIRECTOR JOHN T. Rhines Co, 3015 124 St.		25a. REC'D BY REGISTRAR JUL 10 1968		25b. REGISTRAR'S SIGNATURE Charles Judge	

(M)
17

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

MANNER OF DEATH

AGE

SEX

RACE

EDUCATION

OCCUPATION

RELIGION

DATE OF BIRTH

PLACE OF BIRTH

DATE OF MARRIAGE

PLACE OF MARRIAGE

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

MANNER OF DEATH

AGE

SEX

RACE

EDUCATION

OCCUPATION

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-2. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

18-22a Film 405 DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10473

1. DECEASED-NAME (Type or Print) Clara K Hartley						2a. DATE KNOWN OF ESTI- DEATH MATED <input checked="" type="checkbox"/> 7-17-68 19			2b. HOUR 2:00pm		
3. SEX Female		4. RACE White		5. DATE OF BIRTH 11-17-1917		6. AGE (In years last birthday) 50 YRS.		IF UNDER 1 YEAR MONTHS _____ DAYS _____		IF UNDER 24 HRS. HOURS _____ MIN _____	
7a. BIRTHPLACE (State or foreign country) VIRGINIA				7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Prince George's Md.			
10. CITY OR TOWN OF DEATH Riverdale				11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Leland Memorial Hospital				12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) CLERK-TYPIST		12b. KIND OF BUSINESS OR INDUSTRY UNION	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland				13b. COUNTY Prince George's		13c. CITY OR TOWN Hyattsville		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 4205 Van Buren Street	
14. FATHER'S NAME First Middle Last EMMETT L. KITCHEN				15. MOTHER'S MAIDEN NAME First Middle Last CORA LEE BRANCH							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO				16b. SOCIAL SECURITY NO. (If yes give war or dates of service) 578-10-4177		17. INFORMANT JASPER P. HARTLEY				ADDRESS SAME AS # 13e	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Barbiturate intoxication 9500 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) 9702											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY Month, Day, Year 1:00 P.M. 7-17 19 68		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) Ingested overdose of barbiturates					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) Home		21f. LOCATION Street or R.F.D. No. City or Town County State Hyattsville Pr. Geo. Md.							
22a. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE EXAMINER'S NAME (Type) John Kehoe MD				RIVERDALE, Md.				CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> ADDRESS (Street, city, town, or county)		22b. DATE SIGNED 7-18-68	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL				23b. DATE 7/20/68		23c. NAME OF CEMETERY OR CREMATORY NATIONAL MEMORIAL PARK				23d. LOCATION (City or Town) (County) (State) FALLS CHURCH, VIRGINIA	
24. FUNERAL DIRECTOR Joseph Sawler, Son Inc.						ADDRESS 5130 Wisconsin Ave., N.W.		25a. REC'D BY REGISTRAR DE JUL 23 1968		25b. REGISTRAR'S SIGNATURE J. Charles Judge	

6 JUL 2 9 1988

1/15/88

John A. ...

[Handwritten signature]

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
CERTIFICATE OF DEATH									
1. DECEASED-NAME (Type or print)			First	Middle	Last	2a. DATE OF DEATH Month Day Year			2b. HOUR
Samuel			H.		Harvey	7 27 68			1:55 PM
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)		IF UNDER 1 YEAR MONTHS DAYS	
Male		White		July 7, 1894		74 YRS.			
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH			
CONN.		USA				Prince George, Md.			
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)			12b. KIND OF BUSINESS OR INDUSTRY
Hyattsville			Hyattsville Nursing Home			President			Dairy
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE			13b. COUNTY			13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	13e. STREET AND NUMBER
Md.			Prince George			College Park		YES	7304 Princeton ave.
14. FATHER'S NAME			First	Middle	Last	15. MOTHER'S MAIDEN NAME			First Middle Last
Samuel			B.		Harvey	Evelyn			Bennett
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown			16b. SOCIAL SECURITY NO.			17. INFORMANT			Address
Yes			214-01-0241			Carol J. Harvey, College Park			Md
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Myocardial Failure</u> 437.9 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Alzheimer's Disease</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Cerebral Arteriosclerosis, advanced</u>									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a)									
334X									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19 68			21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State			
						March 19 68 to July 19 68			
22a. I certify that (I) (this hospital) attended the deceased from July 16, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the cause stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <u>W.L. Etienne</u>						22c. DATE SIGNED 7-27-68			
22d. PHYSICIAN'S NAME (Type) <u>W.L. ETIENNE</u>						22e. ADDRESS <u>College Park, Md</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify)			23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)		
Burial			July 31, 1968		Storrs Cemetery		Storrs Connecticut		
24. FUNERAL DIRECTOR			F. Gasch's Sons			25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	
			Hyattsville, Md.			AUG 1 1968		Charles Judge	

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July 10, 1891

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1902

• 2008-01-19 : 233

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 2 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after the death.

CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or print)		First	Middle	Lost	2a. DATE OF DEATH Month Day Year		2b. HOUR		
GRACE		GRACE	BROCK	HASTE	July 27 1968		8:00A M		
3. SEX	4. RACE		5. DATE OF BIRTH		6. AGE (In years lost birthday)		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		
Female	Caucasian		March 22, 1907		61- YRS.				
7a. BIRTHPLACE (State or foreign country)	7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH		Md.		
N Carolina	USA				Prince Georges				
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY			
Riverdale		Eugene Ieland Memorial		housewife		own home			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
Maryland		Prince Georges		Hyattsville		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
14. FATHER'S NAME		First	Middle	Lost	15. MOTHER'S MAIDEN NAME		First	Middle	Lost
James		James	Brock		Maddy		L	Small	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown		(If yes give war or dates of service)		16b. SOCIAL SECURITY NO.		17. INFORMANT		Address	
no				578-42-0799		Joseph B. Haste		Lanham, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) _____ DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH ONE DAY		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
5702 PARKINSON'S DISEASE									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from 21 JULY, 1968, to 27 JULY, 1968, that (I) (we) last saw the deceased alive on 26 JULY 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE		C J Houmann		DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED			
						27 JULY 68			
22d. PHYSICIAN'S NAME (Type)		C J Houmann		22e. ADDRESS		Eland Hospital Riverdale, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)			
Burial		July 29, 1968		Ft Lincoln Cemetery		Colmar Manor Pro Geo Md.			
24. FUNERAL DIRECTOR		F. Gasch's Sons		Hyattsville Md.		25a. REC'D BY REGISTRAR DATE AUG 1 1968			
						25b. REGISTRAR'S SIGNATURE Charles Judge			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARTLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
10467											
10476											
1. DECEASED-NAME (Type or print) First Middle Last James H. Hedgeman						2a. DATE OF DEATH Month Day Year July 4 1968			2b. HOUR 12:30		
3. SEX Male		4. RACE Negro		5. DATE OF BIRTH 10/14/1899		6. AGE (In years last birthday) 68		IF UNDER 1 YEAR MONTHS DAYS YRS.		IF UNDER 24 HRS. HOURS MIN. YRS.	
7a. BIRTHPLACE (State or foreign country) Virginia		7b. CITIZEN OF WHAT COUNTRY? U. S. A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. COUNTY OF DEATH Prince Georges					
10. CITY OR TOWN OF DEATH Glenn Dale		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Glenn Dale Hospital		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) unknown - retired		12b. KIND OF BUSINESS OR INDUSTRY unknown					
13a. USUAL RESIDENCE (Where deceased admission) STATE STATE		13b. COUNTY ✓		13c. CITY OR TOWN Wash., D.C.		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 636 Farragut St., N. W.			
14. FATHER'S NAME First Middle Last James -- Hedgeman				15. MOTHER'S MAIDEN NAME First Middle Last Nannie Cole							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown yes		16b. SOCIAL SECURITY NO. 1918		16c. SOCIAL SECURITY NO. 579-05-1986		17. INFORMANT Decedent					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cor pulmonale 011.9 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Pulmonary tuberculosis DUE TO, OR AS A CONSEQUENCE OF (c) Pulmonary emphysema										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 mo. 10 yr. 10 yr.	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) 0021											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State							
22a. I certify that (this hospital) attended the deceased from 9/6/ , 19 67 , to 7/4/ , 19 68 , that we (we) last saw the deceased alive on 7/4/ , 19 68 , and that in my (our) opinion death occurred on the date and hour and from the causes stated above, we (we) (did) not view the body after death.											
22b. SIGNATURE Moe Weiss				DEGREE Moe Weiss, M. D.		ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED 7/4/1968			
22d. PHYSICIAN'S NAME (Type) Moe Weiss, M. D.				22e. ADDRESS Glenn Dale Hospital Glenn Dale, Maryland							
23a. BURIAL CREMATION, REMOVAL (Specify) BURIAL		23b. DATE 9 JULY 1968		23c. NAME OF CEMETERY OR CREMATORY LINCOLN MEM.		23d. LOCATION (City or Town) (County) (State) SUITLAND MARYLAND					
24. FUNERAL DIRECTOR ROBERT G. MCQUIRE				25a. REC'D BY REGISTRAR 1820 9th St. BAL - 9 1968		25b. REGISTRAR'S SIGNATURE Charles J. Jones					

FOR STATE
HEALTH-DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-2. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

10468

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10477

1. DECEASED-NAME (Type or Print)			First Elizabeth			Middle Mary			Last Henry			2a. DATE KNOWN OF ESTI- DEATH MATED <input checked="" type="checkbox"/> 7-26-68 1911:00am			2b. HOUR		
3. SEX Female		4. RACE White		5. DATE OF BIRTH 12-3-1895		6. AGE (In years last birthday) 72 YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN		2c. DATE PRONOUNCED DEAD Month Day Year 7 26 68 11:08am			2d. HOUR		
7a. BIRTHPLACE (State or foreign country) Pa.				7b. CITIZEN OF WHAT COUNTRY? U S A				8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				9. COUNTY OF DEATH Prince George's Md.					
10. CITY OR TOWN OF DEATH Riverdale				11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Beland Hospital				12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Housewife				12b. KIND OF BUSINESS OR INDUSTRY None					
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission - STATE Maryland				13b. COUNTY Prince George's				13c. CITY OR TOWN Hyattsville				13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 4009 Gallatin Street, #405			
14. FATHER'S NAME Joseph			First Middle Last Robson			15. MOTHER'S MAIDEN NAME Anna			First Middle Last Morgans								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No				16b. SOCIAL SECURITY NO. (If yes give year or dates of service) None 214300222				17. INFORMANT ADDRESS Lloyd E Henry 4009 Gallatin St.									
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Heart failure</u> <u>4120</u> DUE TO, OR AS A CONSEQUENCE OF <u>Hypertensive cardio vascular disease</u> over 1 yr. Conditions, if any, which gave rise to immediate cause (a), storing the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____														APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH minutes			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <u>443x Diabetes mellitus - over 20 yrs.</u>																	
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 19				21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1B.)									
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)				21f. LOCATION Street or R.F.D. No. City or Town County State									
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>																	
ACTUAL SIGNATURE EXAMINER'S NAME (Type) John Kehoe MD				Riverdale, Md.				CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> ADDRESS (Street, city, town, or county)				22b. DATE SIGNED 7-26-68					
23a. BURIAL, CREMATION REMOVAL (Specify) Burial				23b. DATE 7/29/1968				23c. NAME OF CEMETERY OR CREMATORY Ft. Lincoln Cemetery				23d. LOCATION (City or Town) (County) (State) Colmar Manor, Maryland					
24. FUNERAL DIRECTOR Nalley Funeral Home				ADDRESS Mt. Rainier, Md.				25a. REC'D BY REGISTRAR DATE JUL 29 1968				25b. REGISTRAR'S SIGNATURE J Charles Judge					

FOR STATE
HEALTH DEPT

(M)

(1)

Medical Examination & Certificate of Death

NAME: Henry

AGE: 45

SEX: Male

DATE OF BIRTH: 11-1-1899

PLACE OF BIRTH: [illegible]

RESIDENCE: [illegible]

DATE OF DEATH: [illegible]

PLACE OF DEATH: [illegible]

CAUSE OF DEATH: [illegible]

IMMEDIATE CAUSE: [illegible]

UNDERLYING CAUSE: [illegible]

PERMANENT CAUSE: [illegible]

INTERVIEWED BY: [illegible]

DATE OF INTERVIEW: [illegible]

SIGNATURE: [illegible]

DATE: [illegible]

1900 JUL 2 1900

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

10469				DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201				10478			
CERTIFICATE OF DEATH											
1. DECEASED-NAME (Type or print) First Middle Last Blanche B Herbert				2a. DATE OF DEATH Month Day Year 7-30-68				2b. HOUR 7:05 AM			
3. SEX Female		4. RACE White		5. DATE OF BIRTH 12-12-1970		6. AGE (In years lost birthday) 97 YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (State or foreign country) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Prince Georges Md					
10. CITY OR TOWN OF DEATH Clinton		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Pine View Gardens		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Housewife		12b. KIND OF BUSINESS OR INDUSTRY At Home					
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland		13b. COUNTY St. Charles		13c. CITY OR TOWN Indian Head		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 29 Potomac Ave.			
14. FATHER'S NAME First Middle Last John Lambert Beadd				15. MOTHER'S MAIDEN NAME First Middle Last Mary Eliza Carpenter							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) No		(If yes give war or dates of service)		16b. SOCIAL SECURITY NO. 219-48-4806		17. INFORMANT 29 Potomac Ave, Indian Head, Md Miss Laura B. Yates-Niece					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>RESPIRATORY FAILURE</u> 10 MIN. 5620 DUE TO, OR AS A CONSEQUENCE OF (b) <u>INTESTINAL OBSTRUCTION CHRONIC</u> 3 WKS. (c) <u>LARGE BOWEL</u> DUE TO, OR AS A CONSEQUENCE OF (d) <u>DIVERTICULITIS-DIVERTICULOSIS</u> 3 MOS.										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 5721 PROBABLE CECAL CARCINOMATOSIS											
19a. DATE OF OPERATION None		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED None		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING TO CAUSE OF DEATH (If either, notify medical examiner) None		21b. TIME OF INJURY HOUR A.M. Month Day Year None		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) None							
21d. INJURY OCCURRED While <input type="checkbox"/> at work <input checked="" type="checkbox"/> at home <input type="checkbox"/> on way to or from work None		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) None		21f. LOCATION Street or R.F.D. No. City or Town County State None							
22a. I certify that (this hospital) attended the deceased from 7-10-1968, to 7-30-1968, that (I) last saw the deceased alive on 7-30-1968, and that in (my) opinion death occurred on the date and hour and from the causes stated above, (I) (did) (did not) view the body after death.											
22b. SIGNATURE Arthur Shaver MD		22c. DATE SIGNED 7/30/68		22d. PHYSICIAN'S NAME (Type) ARTHUR SHAVER SR MD 8808 BRANCH AVE CLINTON							
23a. BURIAL, CREMATION, REMOVING BODY Burial		23b. DATE 8/2/1968		23c. NAME OF CEMETERY OR CREMATORY Sacred Heart Cemetery		23d. LOCATION (City or Town) La Plata, Md.		(County) Prince Georges			
24. FUNERAL DIRECTOR Archart Funeral Home, Inc.				ADDRESS La Plata, Md.		25a. REC'D BY REGISTRAR DATE AUG 2 1968		25b. REGISTRAR'S SIGNATURE Charles Judge			

EXHIBIT OF DEATH



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. This page should be removed, and in any event, within 72 hours after death, should be filed with the State Dept. of Health prior to burial, cremation, or removal of the body.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
10470 10479											
CERTIFICATE OF DEATH											
1. DECEASED-NAME (Type or print) First Middle Last LEWIS K HILE						2a. DATE OF DEATH JULY Month 27 Day 1968 Year			2b. HOUR 1138P		
3. SEX MALE		4. RACE WHITE		5. DATE OF BIRTH JUL 18, 1900		6. AGE (In years lost birthday) 67 YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (State or foreign country) Kansas		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH PRINCE GEORGES Md.					
10. CITY OR TOWN OF DEATH CHEVERLY			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) PRINCE			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) VEHICLE INSPECTOR			12b. KIND OF BUSINESS OR INDUSTRY		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE MD			13b. COUNTY P.G.		13c. CITY OR TOWN BOWIE		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 12412 Shelter Lane		
14. FATHER'S NAME First Middle Last DE WITT HILE				15. MOTHER'S MAIDEN NAME First Middle Last Gertie B Zeek							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) (If yes give war or dates of service)			16b. SOCIAL SECURITY NO. 577-105859		17. INFORMANT 7713 Tipton St. Address New Carrollton, Md. F. Gasch's Sons						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CARDIOGENIC SHOCK.</u> 4129 DUE TO, OR AS A CONSEQUENCE OF (b) <u>VENTRICULAR FIBRILLATION</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE</u>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 30 MIN 30 MIN 6 YEARS	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (o) 4331											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.)							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No.		City or Town		County		State	
22a. I certify that (I) (this hospital) attended the deceased from <u>JUNE</u> , 19 <u>66</u> to <u>JULY</u> , 19 <u>68</u> , that (I) (we) lost the deceased on <u>JUNE 24</u> , 19 <u>68</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE Norman K Bohrer				DEGREE M.D.		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED July 28, 1968			
22d. PHYSICIAN'S NAME (Type) Dr Norman Bohrer				22e. ADDRESS 3231 Superior Lane		City or Town Bowie		County Md		State 20745	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE July 31, 1968		23c. NAME OF CEMETERY OR CREMATORY Arlington National		23d. LOCATION (City or Town) Arlington		(County) Virginia		(State)	
24. FUNERAL DIRECTOR F. Gasch's Sons				ADDRESS Hyattsville, Md.		25a. REC'D BY REGISTRAR AUG 1 1968		25b. REGISTRAR'S SIGNATURE Charles Judge			

100-100000

100-100000

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										
104721 MEDICAL EXAMINER'S CERTIFICATE OF DEATH										
1. DECEASED-NAME (Type or Print) First Middle Last Flossie Irene Hill						2a. DATE KNOWN OF ESTI-DEATH MATED <input checked="" type="checkbox"/> 7-12-68 197:00am M		2b. HOUR		
3. SEX Female	4. RACE White	5. DATE OF BIRTH 3-20-1895	6. AGE (In years last birthday) 73 YRS.	IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS HOURS MIN	2c. DATE PRONOUNCED DEAD Month 7 Day 12 Year 68 19 10:25am		2d. HOUR		
7a. BIRTHPLACE (State or foreign country) Virginia		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Prince George's Md.				
10. CITY OR TOWN OF DEATH Riverdale			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Leland Memorial Hospital			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Housewife		12b. KIND OF BUSINESS OR INDUSTRY		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) - STATE Maryland			13b. COUNTY Frederick Brunswick		13c. CITY OR TOWN YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13d. STREET AND NUMBER 538 Brunswick St.			
14. FATHER'S NAME First Middle Last Charles David Albert				15. MOTHER'S MAIDEN NAME First Middle Last Elizabeth Riley						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no			16b. SOCIAL SECURITY NO.		17. INFORMANT Harry Le Roy Hill				ADDRESS Brunswick, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Heart failure</u> 4129 DUE TO, OR AS A CONSEQUENCE OF <u>Arteriosclerotic heart disease</u> over 15 yrs. Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) _____ DUE TO, OR AS A CONSEQUENCE OF _____ (c) _____								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH minutes		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 4200										
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)						
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No.		City or Town		County State		
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>										
ACTUAL SIGNATURE EXAMINER'S NAME (Type) John Kehoe MD		Riverdale, Md.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		22b. DATE SIGNED 7-12-68				
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE 7/15/68		23c. NAME OF CEMETERY OR CREMATORY Park Heights Cemetery		23d. LOCATION (City or Town) (County) (State) Brunswick, Fred. Md.				
24. FUNERAL DIRECTOR Feete Funeral Home				ADDRESS Brunswick, Md.		25a. REC'D BY REGISTRAR DATE JUL 16 1968		25b. REGISTRAR'S SIGNATURE J Charles Judge		

1

835 JUL 1 1968

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

10472 Amable

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

10481

1. DECEASED-NAME (Type or print) <i>Mable</i>			First <i>C.</i> Middle <i>H.</i> Last <i>H.</i>			2a. DATE OF DEATH Month <i>July</i> Day <i>24</i> Year <i>68</i>			2b. HOUR <i>4:18</i> P.M.		
3. SEX <i>Female</i>			4. RACE <i>White</i>			5. DATE OF BIRTH <i>6/2/1892</i>			6. AGE (In years last birthday) <i>86</i> YRS.		
7a. BIRTHPLACE (State or foreign country) <i>N.Y.</i>			7b. CITIZEN OF WHAT COUNTRY? <i>USA</i>			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH <i>Prince Georges</i> Md.		
10. CITY OR TOWN OF DEATH <i>Greenbelt</i>			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>Greenbelt Convalescent Center</i>			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <i>Housewife</i>			12b. KIND OF BUSINESS OR INDUSTRY <i>self</i>		
13a. USUAL RESIDENCE (Where deceased lived, if institution, residence before admission) STATE <i>Md.</i>			13b. COUNTY <i>P.G.</i>			13c. CITY OR TOWN <i>LANHAM</i>			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
13e. STREET AND NUMBER <i>9302 Wellington St.</i>			14. FATHER'S NAME First <i>Harney</i> Middle <i>W.</i> Last <i>Boon</i>			15. MOTHER'S MAIDEN NAME First <i>Alice</i> Middle <i>E.</i> Last <i>Casper</i>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) <i>No</i>			16b. SOCIAL SECURITY NO. <i>055 16 9096</i>			17. INFORMANT <i>Mrs. ALAN C Hill</i>			Address <i>Same</i>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>437.0</i> <i>Coronary Artery Failure</i> DUE TO, OR AS A CONSEQUENCE OF (b) <i>Cerebral Vascular Accident</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i>Hypertensive/arteriosclerotic Cerebral Vascular Change</i>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <i>331X</i>											
19a. DATE OF OPERATION <i>—</i>			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <i>—</i>			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <i>—</i>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year <i>19</i>			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)			21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from <i>July 23</i> , 19 <i>68</i> , to <i>July 24</i> , 19 <i>68</i> , that (I) (we) last saw the deceased alive on <i>July 23</i> , 19 <i>68</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <i>W. L. Etienne</i>			22c. DATE SIGNED <i>7-24-68</i>			22d. PHYSICIAN'S NAME (Type) <i>W. L. ETIENNE</i>			22e. ADDRESS <i>College Park, Md.</i>		
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>			23b. DATE <i>July 28, 1968</i>			23c. NAME OF CEMETERY OR CREMATORY <i>Bramanville Cemetery</i>			23d. LOCATION (City or Town) (County) (State) <i>Cobleskill, New York</i>		
24. FUNERAL DIRECTOR <i>F. Gasch's Sons</i>			ADDRESS <i>Hyattsville, Md.</i>			25a. REC'D BY REGISTRAR <i>JUL 29 1968</i>			25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15
30M REV 1-68

1. DECEASED-NAME (Type or print)				First Middle Last		2a. DATE OF DEATH				2b. HOUR	
JAMES				HIMICH		July Month 10 Day 68 Year				0010 M	
3. SEX		4. RACE		5. DATE OF BIRTH				6. AGE (In years lost birthday)		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
Male		Caucasion		16 Dec 1888				79 YRS.			
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH					
Hungary		USA				Prince George's County Md.					
10. CITY OR TOWN OF DEATH				11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)				12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY	
Andrews AFB				Malcolm Grow USAF Hosp				Military			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE				13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER	
Maryland				Caroline		Greensboro				Box 243	
14. FATHER'S NAME First Middle Last				15. MOTHER'S MAIDEN NAME First Middle Last							
UNKNOWN				UNKNOWN							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown				16b. SOCIAL SECURITY NO.		17. INFORMANT				Address	
Yes				1906-1932		Son-10				16th St. Englewood Cliffs, NJ	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY:											
IMMEDIATE CAUSE (a) 1541										Sudden	
DUE TO, OR AS A CONSEQUENCE OF (b) Cancer of Rectum										?	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.											
DUE TO, OR AS A CONSEQUENCE OF (c)											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)											
154x											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No.		City or Town		County		State	
22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) lost the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE						DEGREE		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED	
Frank A. Camp										10 July 68	
22d. PHYSICIAN'S NAME (Type) FRANK A CAMP MAJ USAF MC						22e. ADDRESS MALCOLM GROW USAF HOSP, ANDREWS AFB, MD					
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town)		(County)		(State)	
Burial		7-13-68		Greensboro		Greensboro		Md.			
24. FUNERAL DIRECTOR						ADDRESS		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	
J.E. Boulaie						Greensboro, Md.		JUL 15 1968		Charles Judge	

MEDICAL CERTIFICATION

(M)

STATEMENT OF DEATH

NAME: JAMES J. JONES
AGE: 35
DATE OF BIRTH: 10-10-1935
PLACE OF BIRTH: [illegible]
OCCUPATION: [illegible]
CAUSE OF DEATH: [illegible]
DATE OF DEATH: [illegible]
PLACE OF DEATH: [illegible]

DECEASED'S SIGNATURE: [illegible]
WITNESSES: [illegible]
DATE: [illegible]

DECLARATION: I, the undersigned, being a competent person, do hereby certify that the foregoing is a true and correct statement of the facts and circumstances surrounding the death of the deceased.

SIGNATURE OF DECLARANT: [illegible]
DATE: [illegible]

NOTARY PUBLIC: [illegible]
DATE: [illegible]

STATE OF [illegible]
COUNTY OF [illegible]

FILE NO. [illegible]
DATE OF FILING: [illegible]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or print) Emmons			First Middle Last -- Holman			2a. DATE OF DEATH Month July Day 3 Year 1968			2b. HOUR 10:00 PM		
3. SEX Male			4. RACE Negro			5. DATE OF BIRTH 1/5/1905			6. AGE (In years last birthday) 63 YRS.		
7a. BIRTHPLACE (State or foreign country) N. C.			7b. CITIZEN OF WHAT COUNTRY? U.S.A.			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> SEPARATED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH Prince Georges		
10. CITY OR TOWN OF DEATH Glenn Dale			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Glenn Dale Hospital			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) unemployed- unknown			12b. KIND OF BUSINESS OR INDUSTRY --		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE D.C.			13b. COUNTY --			13c. CITY OR TOWN Wash., D. C.			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		
14. FATHER'S NAME First Middle Last Unknown			15. MOTHER'S MAIDEN NAME First Middle Last Maggie -- Holman			16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes give war or dates of service) yes 1939-1945			16b. SOCIAL SECURITY NO. 579-05-1537		
17. INFORMANT Decedent			18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) RECURRENT CEREBROVASCULAR ACCIDENT 4120 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. 443X (b) 443X DUE TO, OR AS A CONSEQUENCE OF (c) HYPERTENSIVE CARDIOVASCULAR DISEASE YEARS			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 DAY					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(c) PULMONARY TUBERCULOSIS, CORONARY ARTERY DISEASE											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? YES		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that the (this hospital) attended the deceased from 2/9/1968 , to 7/3/1968 , that we (we) last saw the deceased alive on 7/3/1968 , and that in my (our) opinion death occurred on the date and hour and from the causes stated above, the (we) (did) not view the body after death.											
22b. SIGNATURE Moe Weiss						DEGREE ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			22c. DATE SIGNED 7/3/1968		
22d. PHYSICIAN'S NAME (Type) Moe Weiss, M. D.						22e. ADDRESS Glenn Dale Hospital Glenn Dale, Maryland					
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL			23b. DATE JULY 9, 1968			23c. NAME OF CEMETERY OR CREMATORY HARMONY MEMORIAL CEMETERY			23d. LOCATION (City or Town) (County) (State) LANDOVER Md		
24. FUNERAL DIRECTOR William Spangler			ADDRESS Spangler Fun. Home 5248 St. N.E. Wash. D.C.			25a. REC'D BY REGISTRAR JUL 10 1968			25b. REGISTRAR'S SIGNATURE Charles Judge		

estru

2742 Qian

191-221

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MAY 5 1968 DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
<div style="display: flex; justify-content: space-between;"> 10475 Item 5 Film 4103 87 380 RB 10484 </div>									
1. DECEASED-NAME First Middle Last Beatrice Jackson						2a. DATE KNOWN OF ESTI-DEATH MATED <input type="checkbox"/> Month Day Year 7-28-68 191:00am		2b. HOUR 191:00am	
3. SEX Female		4. RACE Negro		5. DATE OF BIRTH 1919 5-17-1919		6. AGE (In years last birthday) 19 YRS.		7c. DATE PRONOUNCED DEAD Month Day Year 7 28 68 191:26am	
7a. BIRTHPLACE (State or foreign country) W.D.C.			7b. CITIZEN OF WHAT COUNTRY? USA			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Prince George's Md.	
10. CITY OR TOWN OF DEATH Cheverly				11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Prince George Hospital				12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Student	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE District of Columbia				13b. COUNTY Washington		13c. CITY OR TOWN Washington		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME First Middle Last CHARLES W JACKSON				15. MOTHER'S MAIDEN NAME First Middle Last BEATRICE WHITE					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO				16b. SOCIAL SECURITY NO. UNKNOWN		17. INFORMANT ADDRESS BEATRICE WHITE 322-54th ST NE W.D.C.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Evisceration 8147 DUE TO, OR AS A CONSEQUENCE OF Laceration of abdominal wall Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO, OR AS A CONSEQUENCE OF (c)									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 8124									
19a. DATE OF OPERATION 7-28-68				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? Pedestrian struck by car.				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY Month, Day, Year 1:00am 7-28- 19 68		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) Pedestrian struck by car.					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) Rt. 50 at Cheverly exit, Prince George County, Maryland		21f. LOCATION Street or R.F.D. No. City or Town County State Prince George County, Maryland					
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>									
ACTUAL SIGNATURE John Kehoe MD				CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>				22b. DATE SIGNED 7-29-68	
EXAMINER'S NAME (Type) John Kehoe MD Riverdale, Md.				ADDRESS (Street, city, town, or county) 1400 Chapin St.					
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE 8/3/68		23c. NAME OF CEMETERY OR CREMATORY HARMONY		23d. LOCATION (City or Town) (County) (State) Landover A.G. 201 MD			
24. FUNERAL DIRECTOR W.W. Chambers				ADDRESS 1400 Chapin St.		25a. REC'D BY REGISTRAR AUG 6 1968		25b. REGISTRAR'S SIGNATURE Charles J. J...	

TO : DIRECTOR, FBI (100-371171)
FROM : SAC, NEW YORK (100-100000)
SUBJECT: [Illegible]

RE: [Illegible]
[Illegible]

[Illegible]

[Illegible]

[Illegible]

[Illegible]

[Illegible]

[Illegible]

[Illegible]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

10476		DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201				10485		
CERTIFICATE OF DEATH								
1. DECEASED-NAME (Type or print)			First	Middle	Last	2a. DATE OF DEATH Month 29, Day 1968 or		2b. HOUR 4:05P ^M
Baby			Boy	Johnson				
3. SEX Male		4. RACE Negro		5. DATE OF BIRTH July 29, 1968		6. AGE (In years last birthday) YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN 3 43
7a. BIRTHPLACE (State or foreign country) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Prince George's Md.		
10. CITY OR TOWN OF DEATH Cheverly		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Prince Geo. Gen'l Hospital		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission), STATE Washington, D.C.		13b. COUNTY -----		13c. CITY OR TOWN Washington		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 1228 Savahhah St. S.E.
14. FATHER'S NAME Willie			First	Middle	Last	15. MOTHER'S MAIDEN NAME Mary Ellen Barlow		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown)			16b. SOCIAL SECURITY NO.		17. INFORMANT Address			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pneumonia 7701 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Pneumonia secondary of placenta. DUE TO, OR AS A CONSEQUENCE OF (c) PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 7615								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that (I) (the hospital) attended the deceased from 7/29, 1968, to 7/29, 1968, that (I) (we) last saw the deceased alive on 7/29 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.								
22b. SIGNATURE H. E. Altman		DEGREE M.D.		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED 7/29/68		
22d. PHYSICIAN'S NAME (Type) Harry E. Altman, M. D.		22e. ADDRESS 2025 Eye St., NW., Washington, D.C. 20006						
23a. BURIAL, CREMATION, REMOVAL (Specify) 8/17/68		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY Prince Geo. General Hosp.		23d. LOCATION (City or Town) (County) (State) Cheverly, Md.		
24. FUNERAL DIRECTOR HARRY W. PENN, JR., ADMINISTRATOR				25a. REC'D BY REGISTRAR DATE AUG 20 1968		25b. REGISTRAR'S SIGNATURE J. Charles Judge		

JOHNSON, JAMES

1911-12-19

JOHNSON, JAMES

1911-12-19

JOHNSON, JAMES

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JOHNSON, JAMES

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JOHNSON, JAMES

1911-12-19

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VA A15 (4)
30M REV. 1-58

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
CERTIFICATE OF DEATH											
1. DECEASED-NAME (Type or print) <i>Augusta</i>				2a. DATE OF DEATH Month <i>July</i> Day <i>24</i> Year <i>68</i>				2b. HOUR <i>11 45 P M</i>			
3. SEX <i>Female</i>		4. RACE <i>White</i>		5. DATE OF BIRTH <i>8-9-89</i>				6. AGE (in years last birthday) <i>78</i> YRS.		IF UNDER 1 YEAR MONTHS DAYS	
7a. BIRTHPLACE (State or foreign country) <i>Maryland</i>		7b. CITIZEN OF WHAT COUNTRY? <i>United States</i>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <i>Prince Georges</i> Md.					
10. CITY OR TOWN OF DEATH <i>Hyattsville Md</i>				11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>Hyattsville Nursing Home</i>				12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <i>Housewife</i>			
12b. KIND OF BUSINESS OR INDUSTRY <i>Own home</i>				13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <i>Maryland</i>				13b. COUNTY <i>Prince Georges</i>		13c. STREET AND NUMBER <i>3410 Dodge Park Rd</i>	
14. FATHER'S NAME First <i>William</i> Middle <i>Duckett</i> Last <i>King</i>				15. MOTHER'S MAIDEN NAME First <i>Isabella</i> Middle <i>A</i> Last <i>De Val</i>				16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) <i>No</i>			
16b. SOCIAL SECURITY NO. <i>517 30 8615</i>				17. INFORMANT <i>Louise King</i>				Address <i>9901 Edgehill Lane Silver Spring, Md</i>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Myocardial infarction</i> DUE TO, OR AS A CONSEQUENCE OF (b) <i>arteriosclerotic coronary disease</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i>4109</i>											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) <i>201 Parkinson disease, Glaucoma, thick blood</i>											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <i>19</i>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.)							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State							
22a. I certify that (I) (this hospital) attended the deceased from <i>July</i> , 19 <i>67</i> , to <i>July</i> , 19 <i>68</i> , that (I) (we) last saw the deceased alive on <i>23 July</i> 19 <i>68</i> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <i>Robert Deitz</i>				DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>				22c. DATE SIGNED			
22d. PHYSICIAN'S NAME (Type) <i>Robert Deitz</i>				22e. ADDRESS <i>Pro Geo Plaza Hyattsville, Md.</i>							
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE <i>July 27, 1968</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Holy Trinity Cemetery</i>				23d. LOCATION (City or Town) (County) (State) <i>Collington Pro Geo Md.</i>			
24. FUNERAL DIRECTOR <i>F. Gasch's Sons</i>				ADDRESS <i>Hyattsville, Md.</i>				25a. REC'D BY REGISTRAR DATE <i>JUL 29 1968</i>		25b. REGISTRAR'S SIGNATURE <i>J Charles Judge</i>	

RECEIVED

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100 100 100

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
Item #6, Film G402 7/18									
1. DECEASED-NAME (Type or Print) First Middle Last Lawrence Marvin Jones						2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> Month Day Year 7 9 1968		2b. HOUR ab. 11 a M	
3. SEX male	4. RACE white	5. DATE OF BIRTH 10-27-11	6. AGE (In years birthday) 57 56 YRS.	IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.	2c. DATE PRONOUNCED DEAD Month Day Year 7 9 1968		2d. HOUR 11:50 a M	
7a. BIRTHPLACE (State or foreign country) Georgia		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Prince George's			
10. CITY OR TOWN OF DEATH Cheverly		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Prince George's Hospital		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Plumber		12b. KIND OF BUSINESS OR INDUSTRY Plumbing			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Md.		13b. COUNTY P.G.		13c. CITY OR TOWN Chillum		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 1507 Ray Road, Apt. 102	
14. FATHER'S NAME First Middle Last Unknown				15. MOTHER'S MAIDEN NAME First Middle Last Unknown					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes		(If yes give war or dates of service) WW II		16b. SOCIAL SECURITY NO. 577-05-2634		17. INFORMANT ADDRESS 1515 Ray Road Stuart Carneal, Chillum, Md. Apt 102 20782			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute pulmonary Edema 869X DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Acute toxicology -- Librium & alcohol DUE TO, OR AS A CONSEQUENCE OF (c)									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 888.0									
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY Month, Day, Year 9:AM P.M. 7-9 1968		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) Took excess amount of Librium while drinking alcohol					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) Home		21f. LOCATION Street or R.F.D. No. City or Town County State Chillum Pr. Geo. Md.					
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>									
ACTUAL SIGNATURE John Kehoe		M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
EXAMINER'S NAME (Type) John Kehoe M.D., Riverdale, Maryland		22b. DATE SIGNED 7-11-68		ADDRESS (Street, city, town, or county)					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE July 13, 1968		23c. NAME OF CEMETERY OR CREMATORY Ft. Lincoln Cemetery		23d. LOCATION (City or Town) (County) (State) Bladensburg, Maryland			
24. FUNERAL DIRECTOR W. W. CHAMBERS CO. Riverdale, Md.				25a. REC'D BY REGISTRAR JUL 15 1968		25b. REGISTRAR'S SIGNATURE J Charles Judge			

10087

UNITED STATES DEPARTMENT OF AGRICULTURE
BUREAU OF PLANT INDUSTRY

10087
MAY 11 1933

Washington, D.C.

May 11, 1933

Dear Sir:

I have the honor to acknowledge the receipt of your letter of May 10, 1933, regarding the matter mentioned therein.

The Bureau is currently reviewing the information submitted and will endeavor to complete the investigation as soon as possible.

Very truly yours,
Director

Enclosed for your information are two copies of the report of the Bureau of Plant Industry.

I am, Sir, very respectfully,
Very truly yours,
Director

Very truly yours,
Director

Very truly yours,
Director

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

Item 5 film G 403 8/2/68 llw Item #13e Film #G402 7/24/68 vmp DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 CERTIFICATE OF DEATH Items 7a, b8 film G 402 7/24/68																	
1. DECEASED-NAME (Type or print)						First		Middle		Last		2a. DATE OF DEATH		2b. HOUR			
Emma						Joyce						Month July Day 15 Year 68		12.09A			
3. SEX			4. RACE			5. DATE OF BIRTH			6. AGE (In years last birthday)			IF UNDER 1 YEAR		IF UNDER 24 HRS.			
Female			White			23 Feb., 1868			79			MONTHS DAYS		HOURS MIN.			
7a. BIRTHPLACE (State or foreign country)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH								
New York			U.S.A.						Pr. Geo., Md.								
10. CITY OR TOWN OF DEATH				11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)				12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)				12b. KIND OF BUSINESS OR INDUSTRY					
Cheverly				Pr. Geo., Gen., Hosp													
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE				13b. COUNTY				13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER					
Maryland				Pr. Geo.				Mitchellsville		YES		816 University Blvd., E. Villa Rosa Nur. Home					
14. FATHER'S NAME			First			Middle			Last			15. MOTHER'S MAIDEN NAME			First Middle Last		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown)				16b. SOCIAL SECURITY NO.				17. INFORMANT				Address					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
PART 1. DEATH WAS CAUSED BY:																	
IMMEDIATE CAUSE (a) <i>Cerebral thrombosis</i>												2 WKS					
DUE TO, OR AS A CONSEQUENCE OF																	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.												YEARS					
DUE TO, OR AS A CONSEQUENCE OF																	
(c) <i>Cerebral thrombosis</i>												YEARS					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)																	
<i>331X Atherosclerotic heart disease</i>																	
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?								
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1B.)											
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State											
22a. I certify that (I) (this hospital) attended the deceased from <i>7-8</i> , 19 <i>68</i> , to <i>7-15</i> , 19 <i>68</i> , that (I) (we) last saw the deceased alive on <i>7-14</i> , 19 <i>68</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.																	
22b. SIGNATURE <i>Fidel J. Quintana</i>						DEGREE		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED <i>7-15-68</i>							
22d. PHYSICIAN'S NAME (Type) <i>FIDEL J. QUINTANA</i>						22e. ADDRESS <i>12004 MAYCHECK LANE, BOWIE, MD.</i>											
23a. BURIAL, CREMATION, REMOVAL (Specify)			23b. DATE			23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION (City or Town) (County) (State)								
			<i>7-18-68</i>			<i>ARLINGTON</i>			<i>NAT ARLINGTON, VA.</i>								
24. FUNERAL DIRECTOR <i>W.W. Chambers</i>						ADDRESS <i>1400-Chapin St. N.W.</i>		25a. REC'D BY REGISTRAR			25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>						
								DATE <i>JUL 17 1968</i>									



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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



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10480

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

10489

1. DECEASED-NAME (Type or print) Thomas			First Middle Last Joyce			2a. DATE OF DEATH Month July Day 13 Year 1968			2b. HOUR 6:00A^M				
3. SEX Male		4. RACE White		5. DATE OF BIRTH 7/4/99			6. AGE (In years last birthday) 69		IF UNDER 1 YEAR MONTHS YRS.		IF UNDER 24 HRS. HOURS MIN		
7a. BIRTHPLACE (State or foreign country) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH Prince George's			Md.			
10. CITY OR TOWN OF DEATH Cheverly			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Prince Geo. Gen. Hosp.			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Receiving Clerk			12b. KIND OF BUSINESS OR INDUSTRY Dept. Store				
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland			13b. COUNTY Prince Geo.			13c. CITY OR TOWN Hyattsville		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 623 Sheridan St.			
14. FATHER'S NAME First Henry Middle Joyce Last Joyce			15. MOTHER'S MAIDEN NAME First Unknown Middle Unknown Last Unknown										
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> (If yes give war or dates of service)			16b. SOCIAL SECURITY NO. 577 03 6303			17. INFORMANT Alice Joyce Same as #13			Address				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pressure Generalized Peritonitis 5340 DUE TO, OR AS A CONSEQUENCE OF, (b) Delusional of Gastrojejunostomy Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 5458 DUE TO, OR AS A CONSEQUENCE OF, (c) Adrenal hemorrhage Pulmonary edema; peritonitis secondary to gastrojejunostomy PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) adrenal hemorrhage Pulmonary edema; peritonitis secondary to gastrojejunostomy													
19a. DATE OF OPERATION 7/12/68		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED Delusional of Gastrojejunostomy		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes							
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY Hour A.M. 19 Month 7 Day 13 Year 1968		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1B.)									
21d. INJURY OCCURRED While <input type="checkbox"/> Nat while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State									
22a. I certify that (I) (this hospital) attended the deceased from 6/27 , 19 68 , to July 13 , 19 68 , that (I) (we) last saw the deceased alive on 7/13 , 19 68 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.													
22b. SIGNATURE Jerome L. Sandler												22c. DATE SIGNED 13 July '68	
22d. PHYSICIAN'S NAME (Type) Jerome L. Sandler						22e. ADDRESS 106 Irving St., N.W., Washington, D.C.							
23a. BURIAL, CREMATION, REMOVAL (Specify) Cremation		23b. DATE 7/15/68		23c. NAME OF CREMATOR Ft. Lincoln		23d. LOCATION (City or Town) (County) (State) Colmar Manor P.G. Md.							
24. FUNERAL DIRECTOR Francis Gasch's Sons Hyattsville, Md.						25a. REC'D BY REGISTRAR 7/17 1968		25b. REGISTRAR'S SIGNATURE Charles Judge					

CERTIFICATE OF DEATH

10481

10490

1. DECEASED-NAME (Type or print) Nellie J. Kaiser			2a. DATE OF DEATH Month July Day 4 Year 1968			2b. HOUR 7:20 PM	
3. SEX Female		4. RACE Cauc.		5. DATE OF BIRTH July 9, 1901		6. AGE (In years lost birthday) 66 YRS.	
7a. BIRTHPLACE (State or foreign country) W. Va.		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Prince George's Md.	
10. CITY OR TOWN OF DEATH Laurel		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) E. Leland Memorial		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Housewife		12b. KIND OF BUSINESS OR INDUSTRY None	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland		13b. COUNTY P.G.		13c. CITY OR TOWN Laurel		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
13e. STREET AND NUMBER Brookland Bridge Rd.		14. FATHER'S NAME First Middle Last Joseph William Howell		15. MOTHER'S MAIDEN NAME First Middle Last Dora Louise Hauff			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown no		16b. SOCIAL SECURITY NO. no		17. INFORMANT E. Leland Memorial Hosp.		Address 4408 Queensbury Rd.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Myocardial Infarction 250.9 DUE TO, OR AS A CONSEQUENCE OF (b) Arteriosclerotic Disease DUE TO, OR AS A CONSEQUENCE OF (c) Arteriosclerosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a) 260X							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from July 3, 1968 to July 4, 1968 , that (I) (we) saw the deceased alive on July 3, 1968 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) did (did not) view the body after death.							
22b. SIGNATURE Robert L. Wingfield M.D.		DEGREE M.D.		ATTENDING PHYS. <input checked="" type="checkbox"/>		MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	
22d. PHYSICIAN'S NAME (Type) Robert L. Wingfield M.D.		22e. ADDRESS Laurel, Maryland		22c. DATE SIGNED July 4, 1968			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 7-8-68		23c. NAME OF CEMETERY OR CREMATORY Grays Hill Cemetery		23d. LOCATION (City or Town) (County) (State) Laurel Md	
24. FUNERAL DIRECTOR De Witt Sanderson		ADDRESS Laurel Md		25a. REC'D BY REGISTRAR JUL 10 1968		25b. REGISTRAR'S SIGNATURE Charles Judge	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



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10482				DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201				10491			
CERTIFICATE OF DEATH											
1. DECEASED-NAME (Type or print)		First	Middle	Last	2a. DATE OF DEATH		2b. HOUR				
Selena		--	Kemp		Month Day Year July 7 1968		3:30P M				
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years lost birthday)		IF UNDER 1 YEAR		IF UNDER 24 HRS.	
Female		Negro		12/28/1902		65 YRS.		MONTHS DAYS		HOURS MIN.	
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		B. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH					
Va.		U.S.A.				Prince Georges				Md.	
10. CITY OR TOWN OF DEATH.		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY					
Glenn Dale		Glenn Dale Hospital		unknown - retired		unknown					
13a. USUAL RESIDENCE (Where deceased admission) STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER			
STATE		Wash., D.C.						4224 Edson Pl., N. E.			
14. FATHER'S NAME		First	Middle	Last	15. MOTHER'S MAIDEN NAME		First	Middle	Last		
Richard		--	Gilleson	Lottie	--		Henderson				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16b. SOCIAL SECURITY NO.		17. INFORMANT		Address					
no		unknown		Decedent							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		Bilateral bronchopneumonia, probably due to staphylococci		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		10 days					
2509		DUE TO, OR AS A CONSEQUENCE OF		Inter-capillary glomerulosclerosis		unknown					
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 260x		(b)		DUE TO, OR AS A CONSEQUENCE OF		Diabetes mellitus with blindness & neuropathy		10 years			
(c)											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)		Hypertensive & arteriosclerotic cardiovascular disease; focal encephalomalacia, mild									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		Yes			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State							
22a. I certify that xx (this hospital) attended the deceased from 8/24/1966, to 7/7/1968, that xx (we) last saw the deceased alive on 7/7/1968, and that in my (our) opinion death occurred on the date and hour and from the causes stated above, xx (we) (did/did not) view the body after death.											
22b. SIGNATURE		Moe Weiss, M. D.		22c. DATE SIGNED		7/7/1968					
22d. PHYSICIAN'S NAME (Type)		Moe Weiss, M. D.		22e. ADDRESS		Glenn Dale Hospital Glenn Dale, Maryland					
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)					
7/13/68		Hammann Cemetery MD		PRINCE GEORGE MD.							
24. FUNERAL DIRECTOR		25a. READ BY REGISTRAR		25b. REGISTRAR'S SIGNATURE							
Tait Williams 4445 Deans Ave SE		JUL 15 1968		J Charles Judge							

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10483

10492

CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or print)			First	Middle	Lost	2a. DATE OF DEATH Month 5 Day 68 Year			2b. HOUR 0200M			
James			H Klucker			July						
3. SEX Male		4. RACE Caucasion		5. DATE OF BIRTH 31 Jan 1932		6. AGE (In years lost birthday) 36 YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.		
7a. BIRTHPLACE (State or foreign country) Pennsylvania		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Prince George's County Md.						
10. CITY OR TOWN OF DEATH Andrews AFB, Md		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Malcolm Grow USAF Hosp		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Airman		12b. KIND OF BUSINESS OR INDUSTRY Military						
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Michigan			13b. COUNTY Warren		13c. CITY OR TOWN Detroit		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER 144 69 Hendricks			
14. FATHER'S NAME John Klucker			First Middle Lost		15. MOTHER'S MAIDEN NAME Elizabeth Harvey			First Middle Lost				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, go, or unknown) (If yes give war or dates of service) Yes			16b. SOCIAL SECURITY NO. 369 30 0858		17. INFORMANT Mrs. Christine Klucker			Address Same				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Subarachnoid Hemorrhage</u> 4309 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____											APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) 330x												
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? No				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)								
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State								
22a. I certify that (I) (this hospital) attended the deceased from <u>5 July, 1968</u> , to <u>5 July, 1968</u> , that (I) (we) last saw the deceased alive on <u>5 July, 1968</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.												
22b. SIGNATURE <u>Phineas J. Hyams</u>						DEGREE ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED <u>5 July 1968</u>				
22d. PHYSICIAN'S NAME (Type) PHINEAS J. HYAMS, Capt, USAF						22e. ADDRESS Malcolm Grow USAF Hosp Andrews AFB Md						
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE 7-8-68		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State) Detroit, Mich						
24. FUNERAL DIRECTOR W.W. Chambers Co. 517-11 th St. S.E.						25a. REC'D BY REGISTRAR JUL - 9 1968		25b. REGISTRAR'S SIGNATURE Charles Judge				

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

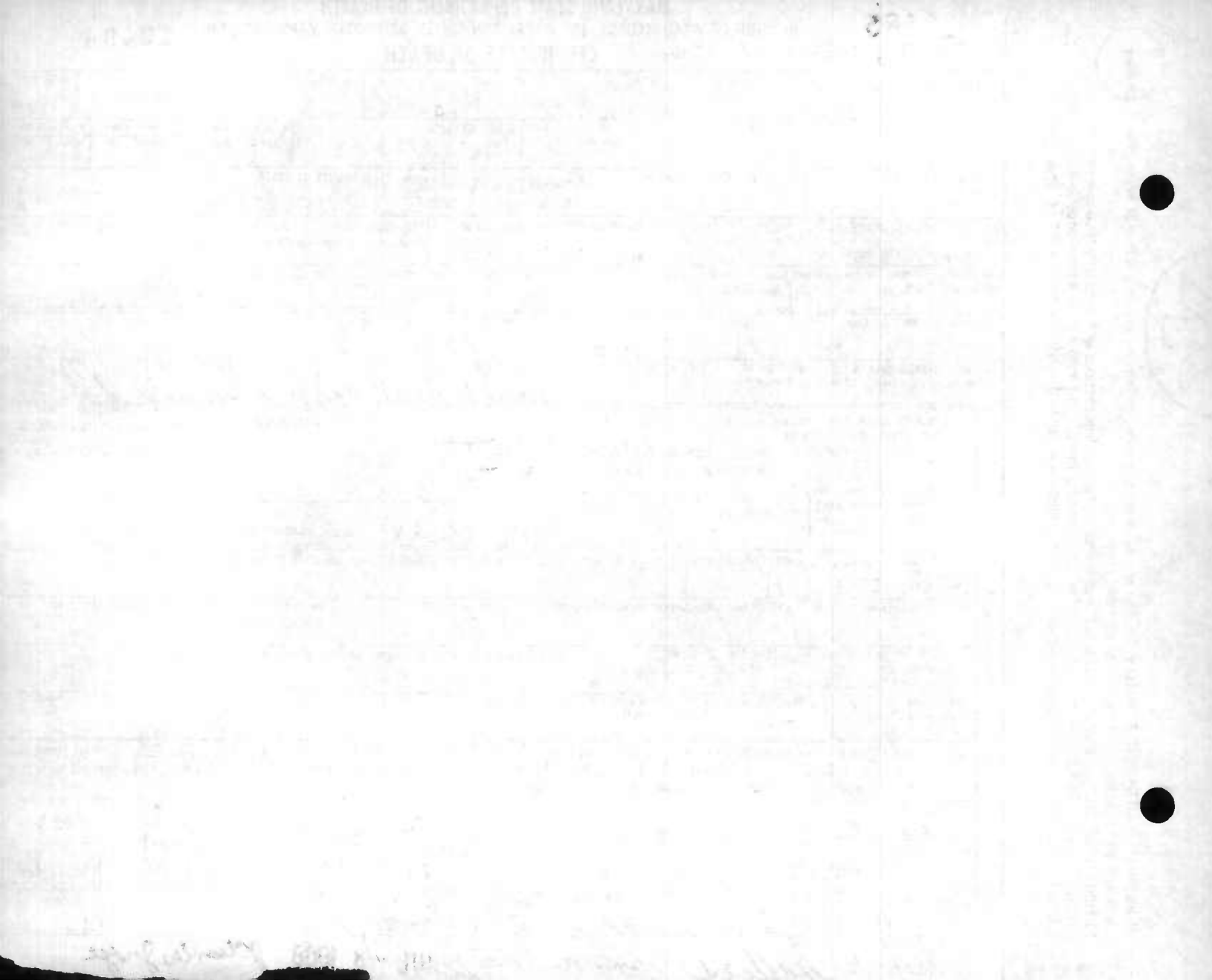
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MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
10486 CERTIFICATE OF DEATH 10493											
1. DECEASED-NAME (Type or print) First Middle Last MAMIE E Klu9					2a. DATE OF DEATH Month Day Year JULY 15 1968		2b. HOUR 11:50 PM				
3. SEX F		4. RACE W		5. DATE OF BIRTH 11/20/175		6. AGE (In years last birthday) 92 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.			
7a. BIRTHPLACE (State or foreign country) Washington D.C.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Prince George Md.					
10. CITY OR TOWN OF DEATH Clinton		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Pineview Gardens			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Nurses Aide		12b. KIND OF BUSINESS OR INDUSTRY Hospital				
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE D.C.			13b. COUNTY Washington		13c. CITY OR TOWN Washington		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 1317 You St. S.E.		
14. FATHER'S NAME First Middle Last Richard Thomas Goddard					15. MOTHER'S MAIDEN NAME First Middle Last Virginia Miller						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) (If yes give war or dates of service) .			16b. SOCIAL SECURITY NO. 579604644T		17. INFORMANT Address Granddaughter 1317 You St S.E. D.C.						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARDIAC ARREST 4129 DUE TO, OR AS A CONSEQUENCE OF (b) ARTERIO SCLEROTIC HEART DISEASE DUE TO, OR AS A CONSEQUENCE OF (c) GENERALIZED ARTERIO SCLEROSIS Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) 4200											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State						
22a. I certify that (I) (this hospital) attended the deceased from 4-5 , 19 68 , to 7-15 , 19 68 , that (I) (we) last saw the deceased alive on 7-15 , 19 68 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE Alfred R Lapin					ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED 7-16-68				
22d. PHYSICIAN'S NAME (Type) ALFRED R LAPIN					22e. ADDRESS CLINTON, MD						
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE July 17, 68		23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery		23d. LOCATION (City or Town) (County) (State) Syitland, Maryland					
24. FUNERAL DIRECTOR Simmons Bros 1661 Hood Rd					25a. REC'D BY REGISTRAR JUL 17 1968		25b. REGISTRAR'S SIGNATURE J Charles Judge				

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

10485 Item #11, Film GL02 7/12/68km										DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										10494									
1. DECEASED-NAME (Type or print) First Middle Last Russell Samuel Krout										2a. DATE OF DEATH 7 Month 2 Day 1968 Year										2b. HOUR 150pM									
3. SEX M					4. RACE W					5. DATE OF BIRTH 12/28/1888					6. AGE (In years last birthday) 79 YRS.					IF UNDER 1 YEAR MONTHS DAYS					IF UNDER 24 HRS. HOURS MIN.				
7a. BIRTHPLACE (State or foreign country) Penn					7b. CITIZEN OF WHAT COUNTRY? USA					8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>					9. COUNTY OF DEATH Prince George Md														
10. CITY OR TOWN OF DEATH Hyattsville					11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Hyattsville Nursing Home					12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)					12b. KIND OF BUSINESS OR INDUSTRY														
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE 47 3 STATE					14b. COUNTY WASH. D. C.					13c. CITY OR TOWN WASH. D. C.					13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>					13e. STREET AND NUMBER 6817 NW 5 th St									
14. FATHER'S NAME First Middle Last Samuel M Krout					15. MOTHER'S MAIDEN NAME First Middle Last Mary																								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes give war or dates of service)					16b. SOCIAL SECURITY NO.					17. INFORMANT Robert R. Krout (son) 7002 Kensington Rd. Laurens Md										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH									
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac arrest</u> 4129 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. <u>4200</u> (b) <u>Complete heart block</u> years (c) <u>Coronary artery heart disease</u> years																													
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) <u>Recent CVA</u>																													
19a. DATE OF OPERATION					19b. CONDITION FOR WHICH OPERATION WAS PERFORMED					20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>					20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?														
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)					21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19					21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)																			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work					21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)					21f. LOCATION Street or R.F.D. No. City or Town County State																			
22a. I certify that (I) (this hospital) attended the deceased from April 30, 1968, to July 2, 1968, that (I) (we) last saw the deceased alive on June 27, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.																													
22b. SIGNATURE Harold W. Draper M.D.					22c. DEGREE M.D.					ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>					22e. DATE SIGNED July 2, 1968														
22d. PHYSICIAN'S NAME (Type) HAROLD W. DRAPER, M.D.					22e. ADDRESS 9801 GEORGIA AVE, S. River Spring Md.																								
23a. BURIAL, CREMATION, REMOVAL (Specify)					23b. DATE July 6-1968					23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery Suitland Md.					23d. LOCATION (City or Town) (County) (State)														
24. FUNERAL DIRECTOR Arthur Walters					ADDRESS 2500 ... St					25a. REC'D BY REGISTRAR JUL 18 1968					25b. REGISTRAR'S SIGNATURE Charles Judge														



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper, pages 1 and 2, and should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

10486

CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or print) Margaret M. Kuhn			2a. DATE OF DEATH July Month 8 Day 68 Year			2b. HOUR 6 P. M.					
3. SEX Female		4. RACE White		5. DATE OF BIRTH April 17, 1892		6. AGE (In years last birthday) 76 YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (State or foreign country) Ireland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Prince Georges Md.					
10. CITY OR TOWN OF DEATH Hyattsville		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Hyattsville Nursing Home		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Retired Nurse		12b. KIND OF BUSINESS OR INDUSTRY Nursing					
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE		13b. COUNTY		13c. CITY OR TOWN Wash., D. C.		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 1708 Newton St., N. W.			
14. FATHER'S NAME First Middle Last Dennis Conroy			15. MOTHER'S MAIDEN NAME First Middle Last Elizabeth Hannan			16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) No (If yes give war or dates of service)					
16b. SOCIAL SECURITY NO. 578-26-2029A			17. INFORMANT Address Mrs. Mary Kanenjar, Daughter, 9505 N.H. Ave. Sil. Spr., Md.								
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 3949 Acute pulmonary embolism acute DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Chronic Cong. heart failure 10 yrs DUE TO, OR AS A CONSEQUENCE OF (c) Mitral stenosis & insufficiency 40 yrs										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) 410X											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1B.)						
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State						
22a. I certify that (I) (this hospital) attended the deceased from July 5, 1968, to July 7, 1968, that (I) (we) last saw the deceased alive on July 7, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE Thomas F. McMahon M.D.					DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED 7-8-68				
22d. PHYSICIAN'S NAME (Type) Thomas F. McMahon M.D.					22e. ADDRESS 3000 - Conn. Ave. N.W.						
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 7-11-1968		23c. NAME OF CEMETERY OR CREMATORY Gate of Heaven Cemetery			23d. LOCATION (City or Town) (County) (State) Silver Spring, Montgomery Co Md.				
24. FUNERAL DIRECTOR Joseph Gawler's Sons, Inc., 5130 Wisc. Ave. N.W., Wash., D.C., 20016					25a. REC'D BY REGISTRAR JUL 10 1968		25b. REGISTRAR'S SIGNATURE Charles Judge				

2000

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2, should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or print) THOMAS J. LANAHAN			2a. DATE OF DEATH Month 7 Day 9 Year 68			2b. HOUR 4:55 M	
3. SEX M		4. RACE W		5. DATE OF BIRTH 9-1-78		6. AGE (In years last birthday) 89 YRS.	
7a. BIRTHPLACE (State or foreign country) IRELAND		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Prince Georges Md.	
10. CITY OR TOWN OF DEATH Greenbelt		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Greenbelt Nursing Home		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Shipping Clerk		12b. KIND OF BUSINESS OR INDUSTRY Western Electric	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE DC.		13b. COUNTY ✓		13c. CITY OR TOWN Washington		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
13e. STREET AND NUMBER 4917 7th Place NE							
14. FATHER'S NAME First Thomas Middle J Last LANAHAN			15. MOTHER'S MAIDEN NAME First MARIA Middle - Last Smith				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) No		16b. SOCIAL SECURITY NO. 577 07 8714		17. INFORMANT Thomas J Lanahan Jr (son)		Address Same as above	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Metastatic Carcinoma Lung 1707 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Carcinoma of Lung DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 Week 2 yrs							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a) 1967							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from August 19, 1968 to 7/7/68 , 19____, that (I) (we) last saw the deceased alive on 7/7 , 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE R.S. Williams MD				DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED 7/7/68	
22d. PHYSICIAN'S NAME (Type) RS WILLIAMS				22e. ADDRESS 35 KENYON AVE NW			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 7-10-1968		23c. NAME OF CEMETERY OR CREMATORY New Cathedral Cem.		23d. LOCATION (City or Town) (County) (State) Baltimore Md.	
24. FUNERAL DIRECTOR ADDRESS Nalley Funeral Home Mt. Rainier, Md.				25a. REC'D BY REGISTRAR DATE JUL 11 1968		25b. REGISTRAR'S SIGNATURE J Charles Jones	

100-100000

UNITED STATES OF AMERICA

100-100000



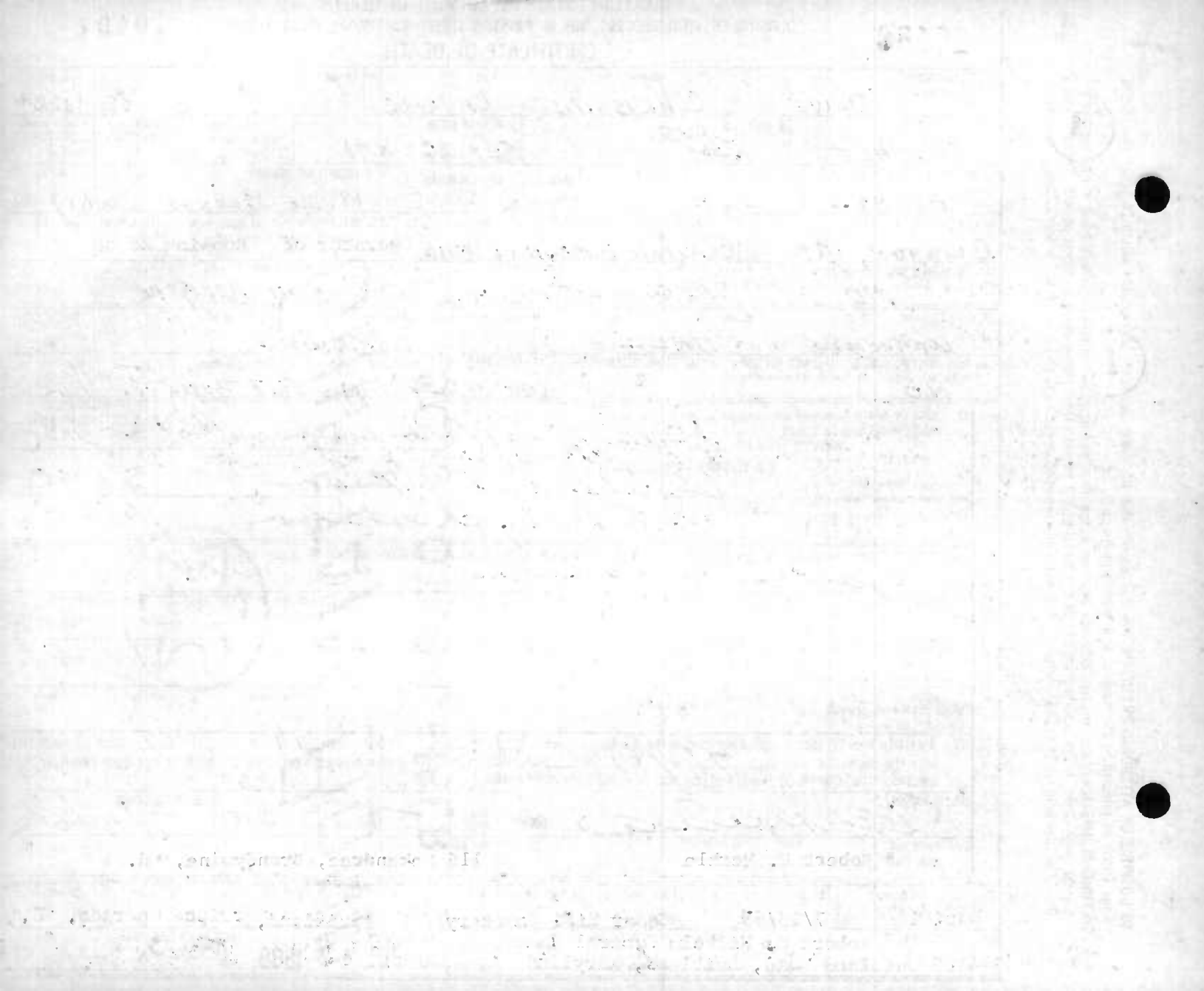
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UNITED STATES OF AMERICA

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
CERTIFICATE OF DEATH									
1. DECEASED-NAME (Type or print)			First Middle Last			2a. DATE OF DEATH			2b. HOUR
OLIVE			CHRISTINE			LARKINS			Month 7 Day 10 Year 68 8:45AM
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
FEMALE		CAUS.		SEP 26 1891		76 YRS.			
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH			
ENGLAND		USA				PRINCE GEORGE COUNTY Md.			
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b. KIND OF BUSINESS OR INDUSTRY			
CLINTON, MD.		CLINTON COMMUNITY HOSPITAL		Operator of rooming house					
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER	
MD.		PR. GEO. CO.		TEMPLE HILLS				5017 BARRY DR.	
14. FATHER'S NAME First Middle Last			15. MOTHER'S MAIDEN NAME First Middle Last						
Unknown			HALL			Unknown			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) (If yes give war or dates of service)			16b. SOCIAL SECURITY NO.			17. INFORMANT Address			
NO			?			WAVENEY HIGGS 5017 Barry Dr Temple Hills			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Hypertensive Arteriosclerosis</u>									UNK
4120 DUE TO, OR AS A CONSEQUENCE OF <u>with some strain</u>									> 1 YR
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Cardiac effusion</u>									UNK
DUE TO, OR AS A CONSEQUENCE OF (c) <u>Chronic depression</u>									UNK
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(c)									
443 X Gastric Hemorrhage 3 Days									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from 7/7, 1968, to 7/10, 1968, that (I) (we) last saw the deceased alive on 7/10/68, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE				DEGREE		ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED	
Robert W. Merkle								7/10/68	
22d. PHYSICIAN'S NAME (Type)				22e. ADDRESS					
Robert W. Merkle				116 Mckendree, Brandywine, Md.					
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)			
Burial		7/15/68		Cedar Hill Cemetery		Suitland, Prince Georges, Md.			
24. FUNERAL DIRECTOR				25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE			
Robert E. Wilhelm Funeral Home 4308 Suitland Road, Suitland, Maryland				DATE JUL 17 1968		Charles Judge			



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TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2, should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

10489										DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										10498									
CERTIFICATE OF DEATH																													
1. DECEASED-NAME (Type or print)					First Middle Last					2a. DATE OF DEATH					2b. HOUR														
Park					--					Lee					Month Day Year					4:00PM									
3. SEX					4. RACE					5. DATE OF BIRTH					6. AGE (In years last birthday)					IF UNDER 1 YEAR MONTHS DAYS					IF UNDER 24 HRS. HOURS MIN.				
Male					Oriental					2/12/1902					66														
7a. BIRTHPLACE (State or foreign country)					7b. CITIZEN OF WHAT COUNTRY?					8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>					9. COUNTY OF DEATH														
China??					USA										Prince Georges Md.														
10. CITY OR TOWN OF DEATH					11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)					12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)					12b. KIND OF BUSINESS OR INDUSTRY														
Glenn Dale					Glenn Dale Hospital					unknown - retired					unknown														
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE					13b. COUNTY					13c. CITY OR TOWN					13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					13e. STREET AND NUMBER									
										Wash., D.C.										805 6th St., N. W.									
14. FATHER'S NAME					15. MOTHER'S MAIDEN NAME																								
First Middle Last					First Middle Last																								
Fook -- Lee					Mache -- Lee																								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> (If yes give war or dates of service)					16b. SOCIAL SECURITY NO.					17. INFORMANT Address																			
no					579-66-2703					Decedent																			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)															APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH														
PART I. DEATH WAS CAUSED BY:																													
IMMEDIATE CAUSE (a) Pulmonary embolus															sudden														
DUE TO, OR AS A CONSEQUENCE OF																													
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: 4500																													
DUE TO, OR AS A CONSEQUENCE OF																													
(c) Generalized arteriosclerosis															unknown														
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)																													
Parkinson's disease.																													
19a. DATE OF OPERATION					19b. CONDITION FOR WHICH OPERATION WAS PERFORMED					20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?														
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)					21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19					21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1B.)																			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>					21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)					21f. LOCATION Street or R.F.D. No. City or Town County State																			
22a. I certify that (X) (this hospital) attended the deceased from 1/26/ 19 68, to 7/2/ 19 68, that (X) (we) last saw the deceased alive on 7/2/ 19 68, and that in (X) (our) opinion death occurred on the date and hour and from the causes stated above (X) (we) (did) (did not) view the body after death.																													
22b. SIGNATURE										DEGREE					ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input type="checkbox"/>					22c. DATE SIGNED									
																				7/2/68									
22d. PHYSICIAN'S NAME (Type)										22e. ADDRESS																			
Moe Weiss, M. D.										Glenn Dale Hospital Glenn Dale, Maryland																			
23a. BURIAL, CREMATION, REMOVAL (Specify)					23b. DATE					23c. NAME OF CEMETERY OR CREMATORY					23d. LOCATION (City or Town) (County) (State)														
Removal					7-14-68					Geo. Wash. Cem.					Hyatts P.G.														
24. FUNERAL DIRECTOR										ADDRESS										25a. REC'D BY REGISTRAR					25b. REGISTRAR'S SIGNATURE				
Lee Funeral Home										300-4th St. N.E. Wash.D.C. 20002										DATE JUL 12 1968					J. Charles Judge				

10-10-68

CONFIDENTIAL

Page

2/1/69

Subject

USA

Date

1. Object of the mission

2. Name of the person

3. Date of the mission

4. Name of the person

5. Date of the mission

6. Name of the person

7. Date of the mission

8. Name of the person

9. Date of the mission

10. Name of the person

11. Date of the mission

12. Name of the person

13. Date of the mission

14. Name of the person

15. Date of the mission

16. Name of the person

17. Date of the mission

18. Name of the person

19. Date of the mission

20. Name of the person

21. Date of the mission

22. Name of the person

23. Date of the mission

24. Name of the person

25. Date of the mission

26. Name of the person

27. Date of the mission

28. Name of the person

29. Date of the mission

30. Name of the person

31. Date of the mission

32. Name of the person

**FOR STATE
HEALTH DEPT.**

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
MEDICAL EXAMINER'S CERTIFICATE OF DEATH									
1. DECEASED-NAME (Type or Print)		First	Middle	Last	2a. DATE KNOWN OF ESTI- DEATH MATED		Month Day Year		2b. HOUR M
GEORGE				LEISLER	JULY 4 1968				
3. SEX	4. RACE	5. DATE OF BIRTH		6. AGE (In years last birthday)	IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS HOURS MIN.	2c. DATE PRONOUNCED DEAD Month Day Year		2d. HOUR M
M	W	June 6 28 40		40 YRS.			JULY 4 1968		5 PM
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH			
Washington		USA				Prince George			
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b. KIND OF BUSINESS OR INDUSTRY		
Cheverly		Prince Geo General Hospital			Unemployed				
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER	
MD		Pr Geo Wash				YES		3970 Pennsylvania	
14. FATHER'S NAME First Middle Last				15. MOTHER'S MAIDEN NAME First Middle Last					
John E Leissler				Ruth Callen					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)				16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS	
Yes				UNKNOWN		Wife Myra Leissler		9931 Annapolis Worship	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Thrombosis</u> DUE TO, OR AS A CONSEQUENCE OF 4109 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 4201									
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>									
ACTUAL SIGNATURE		DAYTON O WATKINS		M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		7-7-68	
EXAMINER'S NAME (Type)		DAYTON O WATKINS				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		22b. DATE SIGNED	
						DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		Dayton Watkins	
						ADDRESS (Street, City or Town, State)		5510 Annapolis Rd Jacksonville, Florida	
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town, County, State)			
Burial		7-7-68		Greenlawn Cemetery		Jacksonville, Florida		No	
24. FUNERAL DIRECTOR Wilhelm Funeral Home 4308 Suitland Rd. SE, Suitland, Maryland						25a. REC'D BY REGISTRAR DATE JUL 16 1968		25b. REGISTRAR'S SIGNATURE J Charles Judge	

10000

MEDICAL EXAMINER, CERTIFICATE OF DEATH

10-22

(M)
10-22

Name of Deceased		John Doe	
Age		45	
Sex		Male	
Race		White	
Date of Death		10-22-1910	
Place of Death		Home	
Cause of Death		Heart Disease	
Disease or Injury		Myocardial Infarction	
Signature of Medical Examiner		[Signature]	
Signature of Coroner		[Signature]	
Signature of Registrar		[Signature]	
Signature of Burial Officer		[Signature]	
Signature of Undertaker		[Signature]	
Signature of Witness		[Signature]	
Signature of Physician		[Signature]	
Signature of Nurse		[Signature]	
Signature of Pharmacist		[Signature]	
Signature of Minister		[Signature]	
Signature of Priest		[Signature]	
Signature of Rabbi		[Signature]	
Signature of Imam		[Signature]	
Signature of Other		[Signature]	

(M)

10-22-1910

10491

CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or print) <i>DIANA Lynn Long</i> <i>Newborn</i>			2a. DATE OF DEATH Month <i>July</i> Day <i>31</i> Year <i>1968</i>			2b. HOUR <i>2030</i>			
3. SEX <i>Female</i>		4. RACE <i>Cauc.</i>		5. DATE OF BIRTH <i>31 July 1968</i>		6. AGE (In years lost birthday) YRS. MONTHS DAYS <i>0 0 18</i>		IF UNDER 1 YEAR IF UNDER 24 HRS.	
7a. BIRTHPLACE (State or foreign country) <i>RAF B Hosp</i>		7b. CITIZEN OF WHAT COUNTRY? <i>USA</i>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <i>Prince Georges</i> Md.			
10. CITY OR TOWN OF DEATH <i>RAF B Hosp.</i>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>Malcom Grow USAF Hosp.</i>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <i>MD.</i>		13b. COUNTY <i>Prince Georges</i>		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER <i>LOOK FOR BIRTH</i> <i>a.a.f.B. Hospital</i>	
14. FATHER'S NAME First <i>JAY</i> Middle <i>HUE</i> Last <i>Long</i>			15. MOTHER'S MAIDEN NAME First <i>GAYNELL</i> Middle <i>Mc</i> Last <i>Millan</i>						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown <i>no</i>		16b. SOCIAL SECURITY NO. <i>---</i>		17. INFORMANT		Address			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>CARDIO-RESPIRATORY ARREST</i> <i>776.2</i> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>IMMATURITY</i> DUE TO, OR AS A CONSEQUENCE OF (c)								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>2 hr 18 min</i> <i>0</i>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <i>7735</i>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <i>yes</i>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year <i>19</i> P.M.		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from <i>31 July, 1968</i> , to <i>31 July, 1968</i> , that (I) (we) lost saw the deceased alive on <i>31 July</i> 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <i>Richard W. Dodds MD</i> DEGREE				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED <i>31 Jul 68</i>			
22d. PHYSICIAN'S NAME (Type) <i>RICHARD W. DODDS</i>				22e. ADDRESS <i>Malcom Grow USAF Hosp, Andrews AFB</i>					
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE <i>8-5-68</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Arlington National</i>		23d. LOCATION (City or Town) (County) (State) <i>Arlington, Virginia</i>			
24. FUNERAL DIRECTOR <i>W. W. Chambers Co. 517-11th St. S.E.</i>				25a. REC'D BY REGISTRAR DATE <i>AUG 6 1968</i>		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. The funeral director should be notified of the death, and in any event, within 72 hours after death.

10701

STATIONER'S COPY

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MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

10501

1. PLACE OF DEATH a. COUNTY <u>Prince Georges</u> MARYLAND b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>PRINCE GEORGES COUNTY HOSPITAL</u>			2. USUAL RESIDENCE (Where deceased lived, if Institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>PRINCE GEORGES</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>MORNINGSIDE MARYLAND</u> d. STREET ADDRESS <u>217 PINE GROVE DRIVE</u>										
3. NAME OF DECEASED (Type or print) First Middle Last <u>CHARLES MICHAEL LUCAS</u>			4. DATE OF DEATH Month Day Year <u>JULY 8 19 68</u>										
5. SEX <u>MALE</u>			6. COLOR OR RACE <u>WHITE</u>										
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			8. DATE OF BIRTH <u>10/16/ 1914</u>										
9. AGE (In years last birthday) <u>53</u> yrs. <table border="1"> <tr> <th colspan="2">IF UNDER 1 YEAR</th> <th colspan="2">IF UNDER 24 HRS.</th> </tr> <tr> <td>Months</td> <td>Days</td> <td>Hours</td> <td>Min.</td> </tr> </table>			IF UNDER 1 YEAR		IF UNDER 24 HRS.		Months	Days	Hours	Min.			
IF UNDER 1 YEAR		IF UNDER 24 HRS.											
Months	Days	Hours	Min.										
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>			10b. KIND OF BUSINESS OR INDUSTRY										
11. BIRTHPLACE (County & State, or foreign country) <u>Ill.</u>			12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>										
13. FATHER'S NAME <u>Martin Lucas</u>			14. MOTHER'S MAIDEN NAME										
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service)			16. SOCIAL SECURITY NO.										
17. INFORMANT <u>EDNA LUCAS</u>			Address <u>217 PINE GROVE DR MORNINGSIDE</u>										
18. CAUSE OF DEATH [Enter only one cause per line for (e), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (e) <u>Coronary Thrombosis</u> 4109 DUE TO Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. } (b) <u>Coronary Arteriosclerosis</u> DUE TO (c)													
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)													
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>													
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)													
20c. TIME OF INJURY Hour e.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)									
20f. (City or town)		(County)		(State)									
21. I certify that (I) (this hospital) attended the deceased from <u>Mar. 12, 1963</u> to <u>July 8, 1968</u> , that (I) (we) last saw the deceased alive on <u>May 25, 1968</u> , and that death occurred at <u>12:00 PM</u> , from the causes and on the date stated above.													
22a. SIGNATURE <u>Frank S. Pellegrini</u> M.D.			22b. DATE SIGNED <u>7.8.68</u>										
22c. PHYSICIAN'S NAME (Type) <u>FRANK S. PELLEGRINI</u>			22d. ADDRESS <u>3611 Branch Ave DE Wash DC 20031</u>										
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Cremation</u>		23b. DATE THEREOF <u>7/11/68</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Lee's Crematorium</u>									
23d. LOCATION (City, town or county) <u>Washington, D. C.</u>		(State)											
24 FUNERAL DIRECTOR'S SIGNATURE <u>Lee Funeral Home</u>			ADDRESS <u>Washington, D. C.</u>										
25a. REC'D BY REGISTRAR DATE <u>JUL 11 1968</u>			25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>										

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 should be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

STATE OF TEXAS
COUNTY OF DALLAS
CERTIFICATE OF DEATH

11

11



11 JUL 1958

11 JUL 1958

11 JUL 1958

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
CERTIFICATE OF DEATH									
1. DECEASED-NAME (Type or print) Daniel J. Lynch					2a. DATE OF DEATH Month 7 Day 3 Year 68			2b. HOUR 12:55 M	
3. SEX Male		4. RACE White		5. DATE OF BIRTH 9/19/75		6. AGE (In years last birthday) 92 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (State or foreign country) Ireland		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Prince George's Md.			
10. CITY OR TOWN OF DEATH Riverdale		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Ireland Memorial		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Farmer		12b. KIND OF BUSINESS OR INDUSTRY			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Md.		13b. COUNTY Prince Geo's		13c. CITY OR TOWN Hyattsville		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 3304 Manorwood Dr.	
14. FATHER'S NAME First Middle Last Unknown					15. MOTHER'S MAIDEN NAME First Middle Last Unknown				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) No			16b. SOCIAL SECURITY NO. 265-34-2934		17. INFORMANT Address Charles Decker Son-in-law Same as above				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 562.1 REMARKS AND SHOCK DUE TO, OR AS A CONSEQUENCE OF Secondary anemia (b) DUE TO, OR AS A CONSEQUENCE OF Tuberculosis of Colon (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 572.1								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3 days 3 days rather much	
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from Jan 30, 1968, to July 3, 1968, that (I) (we) last saw the deceased alive on July 3, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE [Signature] DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>					22c. DATE SIGNED				
22d. PHYSICIAN'S NAME (Type) F. Gasch's Sons					22e. ADDRESS Hyattsville, Maryland				
23a. BURIAL CREMATION, REMOVAL (Type) Removal		23b. DATE 7/4/68		23c. NAME OF CEMETERY OR CREMATORY Stith Funeral Home		23d. LOCATION (City or Town) Danville		(County) (State) Kentucky	
24. FUNERAL DIRECTOR F. Gasch's Sons					25a. REC'D BY REGISTRAR JUL - 8 1968		25b. REGISTRAR'S SIGNATURE [Signature]		

10000

STATE OF OHIO

OFFICE OF THE COMMISSIONER OF LANDS AND MINES

RECEIVED

DECEMBER 10 1900

RECEIVED

DECEMBER 10 1900

RECEIVED

DECEMBER 10 1900

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

Items #5&6 7/31/68 taken from birth cert. vmp

CERTIFICATE OF DEATH

10503

1. PLACE OF DEATH a. COUNTY <u>None</u> Pr. Geo. Co. MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Brandywine Md.</u> c. LENGTH OF STAY IN lb <u>Life time</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Prince George Co.</u>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Brandywine Md.</u> b. COUNTY <u>Prince George</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Danville Road</u> d. STREET ADDRESS <u></u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>BESSIE</u> First Middle Last 4. DATE OF DEATH <u>JULY</u> Month Day Year <u>23</u> 19 <u>68</u>		5. SEX <u>Female</u> 6. COLOR OR RACE <u>White</u> 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> 8. DATE OF BIRTH <u>9/2/1905</u> 9. AGE (In years last birthday) <u>62</u> yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) <u>Brandywine Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>United States</u>	
13. FATHER'S NAME <u>Herbert Albert Young</u>		14. MOTHER'S MAIDEN NAME <u>Janie Dorienda Butler Young</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO. <u>579-44-6583</u>	
17. INFORMANT <u>Robert Mahoney - Danville Rd. Brandywine Md.</u> Address			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (d).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>1922</u> <u>TERMINAL BRONCHOPNEUMONIA</u> DUE TO (b) <u>METASTATIC CARCINOMA CERVICAL SPINE 6 MONTHS</u> DUE TO (c) <u>UNKNOWN PRIMARY</u>		INTERVAL BETWEEN ONSET AND DEATH <u>1 DAY</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>1931</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. _____ 19 _____		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>Nov. 1</u> , 19 <u>67</u> , to <u>JULY 23</u> , 19 <u>68</u> , that (I) (<u>was</u>) last saw the deceased alive on <u>July 23</u> , 19 <u>68</u> , and that death occurred at <u>2 P.M.</u> , from causes and on the date stated above.			
22a. SIGNATURE <u>Thomas S. Sappington</u> M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>July 23, 1968</u>	
22c. PHYSICIAN'S NAME (Type) <u>THOMAS S. SAPPINGTON</u>		22d. ADDRESS <u>2233 WISCONSIN AVE. NW, WASH. D.C.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>July 27-1968</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Union Bethel Ch. Cem.</u>		23d. LOCATION (City or Town) (County) (State) <u>Brandywine Pr. Geo. Md.</u>	
24. FUNERAL DIRECTOR <u>Martell Adams</u> ADDRESS <u>Ciguasco Md.</u>		25a. REC'D BY REGISTRAR <u>JUL 30 1968</u> 25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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U.S. DEPARTMENT OF AGRICULTURE
WASHINGTON, D.C.

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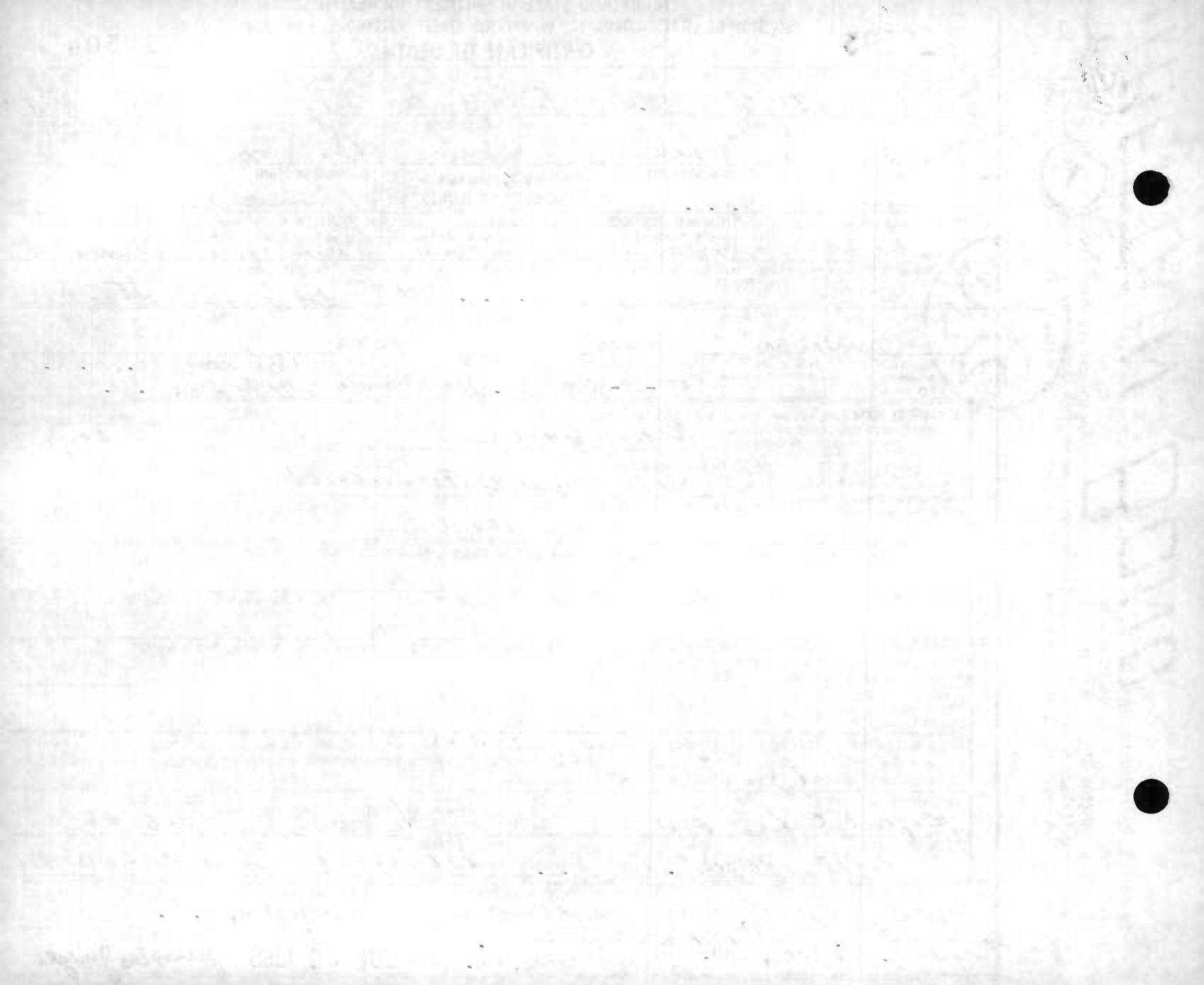
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 and should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 48 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or print) Charles D. Mandes			2a. DATE OF DEATH July 6 1968			2b. HOUR 10²⁰ A.M.			
3. SEX male		4. RACE White		5. DATE OF BIRTH unknown 1881		6. AGE (In years last birthday) 87 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN	
7a. BIRTHPLACE (State or foreign country) Greece		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Prince Georges Md.			
10. CITY OR TOWN OF DEATH Lanham		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) magnolia Gardens Home		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Retired Owner		12b. KIND OF BUSINESS OR INDUSTRY Restaurant			
13a. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) STATE D.C.		13b. COUNTY		13c. CITY OR TOWN Wash. D.C.		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 1416-15th Street	
14. FATHER'S NAME First Demetrius Middle Mandes Last			15. MOTHER'S MAIDEN NAME First Unknown Middle Last						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) No (If yes give war or dates of service)		16b. SOCIAL SECURITY NO. 577-48-8026		17. INFORMANT Dr. James Mandes		1355 Adams Rd. N.W. Washington, D.C.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Renal Failure 2509 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Generalized arteriosclerosis DUE TO, OR AS A CONSEQUENCE OF (c) Diabetes Mellitus							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 days		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 260x									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from 7-4-68 , 19 68 , to 7-6 , 19 68 , that (I) (we) last saw the deceased alive on 7-4 , 19 68 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE Rafael C. Lee M.D. DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>					22c. DATE SIGNED 7-6-68				
22d. PHYSICIAN'S NAME (Type) RAF. Rafael C. Lee M.D.					22e. ADDRESS 426 Irvington ST SE, OROZ HILL MD				
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE July 10, 1968		23c. NAME OF CEMETERY OR CREMATORY Glenwood Cemetery		23d. LOCATION (City or Town) (County) (State) Washington, D.C.			
23a. REC'D BY REGISTRAR Warner C. Humphrey, Inc.		23b. REGISTRAR'S SIGNATURE Charles Judge		23c. ADDRESS 8434 Georgia Ave. Silver Spring, Md.		23d. DATE JUL 12 1968			



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TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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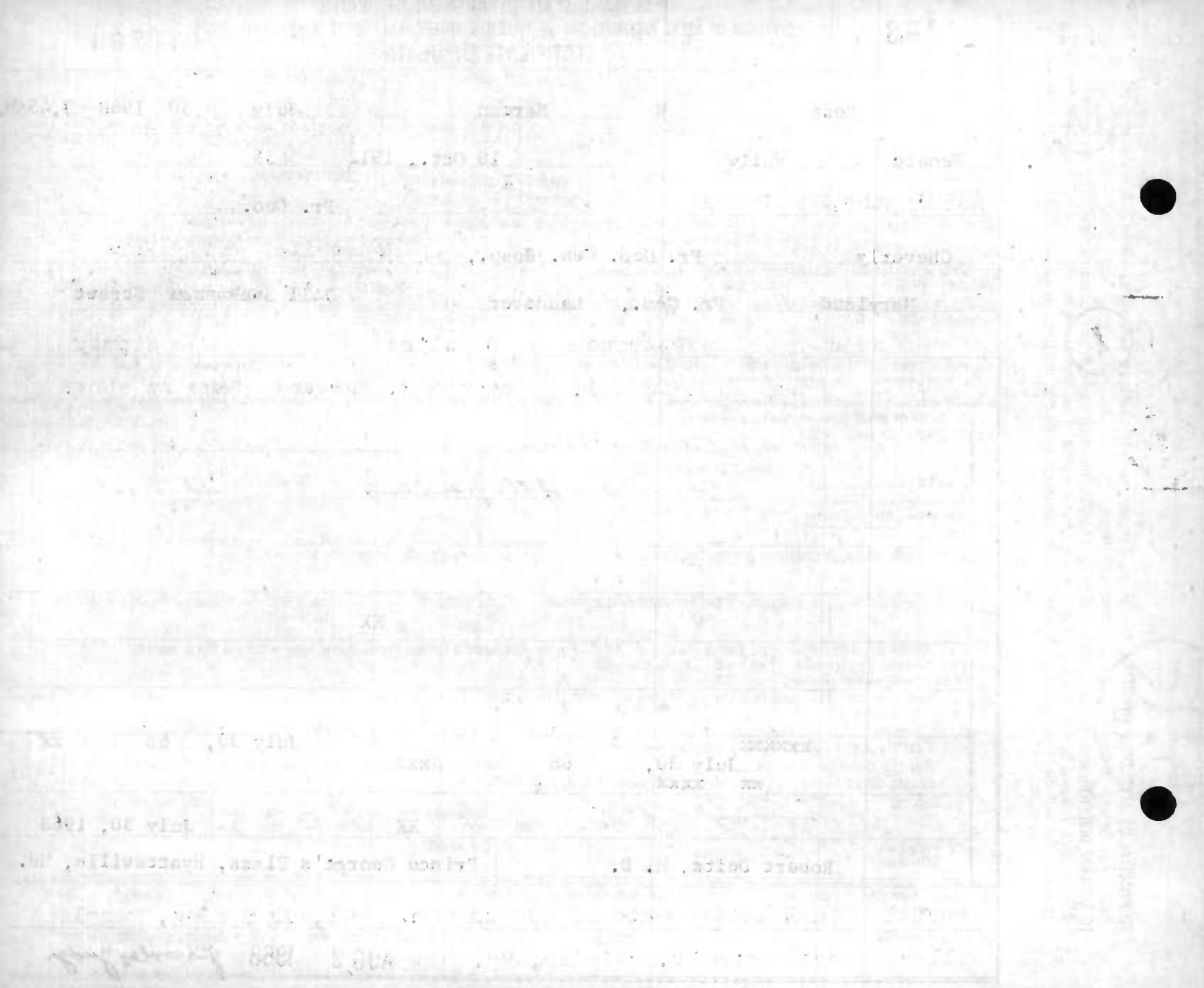
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DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

10505

CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or print)			First	Middle	Last	2a. DATE OF DEATH Month Day Year			2b. HOUR		
Rose			M		Marean	July 30 1968			3.45AM		
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN	
Female		White		10 Oct., 1912		55					
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH					
Washington, DC		U S A				Pr. Geo.					
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)			12b. KIND OF BUSINESS OR INDUSTRY		
Cheverly			Pr. Geo. Gen. Hosp.,			housewife			None		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE			13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER		
Maryland			Pr. Geo.,		Landover		YES <input type="checkbox"/> NO <input type="checkbox"/>		7411 Buchanan Street		
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME								
First Middle Last			First Middle Last								
Claude			Petrone			Madoline Stottly					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) (If yes give war or dates of service)			16b. SOCIAL SECURITY NO.		17. INFORMANT			Address			
No			None		579221448			Raymond F. Marean Same as above			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral</u> <u>157.9</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Concussion of the brain.</u> DUE TO, OR AS A CONSEQUENCE OF (c)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <u>157X</u>											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1B.)						
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State						
22a. I certify that (I) (the physician) attended the deceased from <u>17 July, 1968</u> , to <u>July 30, 1968</u> , that (I) (we) saw the deceased alive on <u>July 30, 1968</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE					DEGREE		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED		
									July 30, 1968		
22d. PHYSICIAN'S NAME (Type)					22e. ADDRESS						
Robert Deitz, M. D.					Prince George's Plaza, Hyattsville, Md.						
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION (City or Town) (County) (State)				
Burial		8/2/1968		Gate of Heaven Cem.			Silver Spring, Maryland				
24. FUNERAL DIRECTOR						25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE			
Nalley Funeral Home Mt. Rainier, Md.						DATE AUG 2 1968		Charles Judge			



FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PMS-Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
MEDICAL EXAMINER'S CERTIFICATE OF DEATH											
1. DECEASED-NAME (Type or Print) <i>VAILE JACOBSON M. Daniel</i>						2a. DATE KNOWN OF DEATH Month <i>7</i> Day <i>1</i> Year <i>1968</i>			2b. HOUR <i>M</i>		
3. SEX <i>M</i>		4. RACE <i>W</i>		5. DATE OF BIRTH <i>Dec 5 1924</i>		6. AGE (in years last birthday) <i>43</i>		IF UNDER 1 YEAR MONTHS <i>4</i> DAYS <i>3</i>		IF UNDER 24 HRS HOURS <i>4</i> MIN <i>3</i>	
7a. BIRTHPLACE (State or foreign country) <i>Virginia</i>			7b. CITIZEN OF WHAT COUNTRY? <i>USA</i>			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH <i>Prince Georges</i>		
10. CITY OR TOWN OF DEATH <i>Chesley</i>				11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>Prince Georges Dist. Mmaga Warehouse Food</i>				12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <i>MD</i>				13b. COUNTY <i>Pr Geo</i>		13c. CITY OR TOWN <i>Coral Hills</i>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER <i>5215 Horner</i>	
14. FATHER'S NAME First <i>Jackson</i> Middle <i>M</i> Last <i>Daniel</i>						15. MOTHER'S MAIDEN NAME First <i>Ruth</i> Middle <i>Davis</i> Last <i></i>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>no</i>				16b. SOCIAL SECURITY NO. <i>WW 2 578288440</i>		17. INFORMANT <i>Betty Granger Suitland</i>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Coronary Thrombosis few minutes</i> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <i>4109</i> (b) <i>Coronary Sclerosis</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i></i>											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a) <i>4201</i>											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY Month, Day, Year HOUR A.M. <i>19</i> P.M. <i></i>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)				21f. LOCATION Street or R.F.D. No.		City or Town		County State	
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE <i>Dayton O Walker</i>				CHIEF MEDICAL EXAMINER <input type="checkbox"/>				22b. DATE SIGNED <i>7-168</i>			
EXAMINER'S NAME (Type) <i>DAYTON O WALKER</i>				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>				ADDRESS (Street, city, town, or county) <i>5318 Annapolis Beadlesburg</i>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>BURIAL</i>		23b. DATE <i>7-5-68</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Fort Lincoln Cemetery</i>				23d. LOCATION (City or Town) (County) (State) <i>PG County, Maryland</i>			
24. FUNERAL DIRECTOR <i>Wilhelm Funeral Home</i>						25a. REC'D BY REGISTRAR <i>JUL 11 1968</i>		25b. REGISTRAR'S SIGNATURE <i>J Charles Judge</i>			
4308 Suitland Road, SE, Suitland, Maryland											

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

10507

CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or print) MARY			First	Middle	Last	2a. DATE OF DEATH Month 7 Day 15 Year 1968			2b. HOUR 10:30 A.		
3. SEX FEMALE		4. RACE White		5. DATE OF BIRTH 7/28-1879		6. AGE (In years last birthday) 88 YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (State or foreign country) Maryland		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Prince Georges Md.					
10. CITY OR TOWN OF DEATH Forestville		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Regent Hotel Nsg. Center		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Housekeeper		12b. KIND OF BUSINESS OR INDUSTRY Own Home					
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Md.		13b. COUNTY Pr. Geo's		13c. CITY OR TOWN Berksire		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 7310 Eusey St.			
14. FATHER'S NAME First Roderick M. Middle McGregor Last Bowie			15. MOTHER'S MAIDEN NAME First Elizabeth Middle -- Last Bowie								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) No		(If yes give war or dates of service) --		16b. SOCIAL SECURITY NO. --		17. INFORMANT Address Miss Grace M. Wood-Same as Item 13-c					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Coronary thrombosis 20 min 4109 DUE TO, OR AS A CONSEQUENCE OF (b) Arteriosclerotic heart disease 10 Yrs. DUE TO, OR AS A CONSEQUENCE OF (c) --										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) 4201											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State							
22a. I certify that (I) (this hospital) attended the deceased from 10-5 , 19 66 , to 7-15 , 19 68 , that (I) (we) last saw the deceased alive on 7-15 , 19 68 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above; (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE W B Sheer M.D.		DEGREE		ATTENDING PHYS. <input checked="" type="checkbox"/>		MED. DIRECTOR <input type="checkbox"/>		STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED July 15, 1968	
22d. PHYSICIAN'S NAME (Type) WALTER B. SHEER		22e. ADDRESS 6400 MARLBORO PIKE, WASH. D.C.									
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 7/18/68		23c. NAME OF CEMETERY OR CREMATORY Epiphany Cemetery				23d. LOCATION (City or Town) (County) (State) Forestville Pr. Geo Md.			
24. FUNERAL DIRECTOR Ritchie Bros. Upper Marlboro, Md.				ADDRESS		25a. REC'D BY REGISTRAR DATE JUL 24 1968		25b. REGISTRAR'S SIGNATURE J Charles Jones			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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10499		DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201				10508				
CERTIFICATE OF DEATH										
1. DECEASED-NAME (Type or print) John			First Middle Last			2a. DATE OF DEATH July Month 6 Day 1968 Year		2b. HOUR 10 A		
3. SEX Male		4. RACE White		5. DATE OF BIRTH 13 April 1902		6. AGE (In years lost birthday) 66 YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN		
7a. BIRTHPLACE (State or foreign country) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Prince George's Md.				
10. CITY OR TOWN OF DEATH Riverdale		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) 6207 44th. Ave.		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Chief Eng.		12b. KIND OF BUSINESS OR INDUSTRY U of Md.				
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland		13b. COUNTY Pr. Geo.		13c. CITY OR TOWN Riverdale		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 6207 - 44th. Avenue		
14. FATHER'S NAME Robert			First Middle Last McKnight			15. MOTHER'S MAIDEN NAME Annie			First Middle Last Meun	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) NO		16b. SOCIAL SECURITY NO. 248-20-1432		17. INFORMANT Address Maryland Margaret McKnight-6207-44th. Ave., Riverdale,						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bronchogenic carcinoma with metastasis to brain 1621 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO, OR AS A CONSEQUENCE OF (c) DUE TO, OR AS A CONSEQUENCE OF APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 yrs.										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 1621 Pulmonary emphysema										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)						
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State						
22a. I certify that (I) (we) attended the deceased from 14 July , 19 59 , to 6 July , 19 68 , that (I) (we) last saw the deceased alive on 2 July , 19 68 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (do not) view the body after death.										
22b. SIGNATURE <i>William B. Gunther</i>		DEGREE William B. Gunther, M. D.		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED 6 July 1968				
22d. PHYSICIAN'S NAME (Type)		22e. ADDRESS 4917 Edgewood Road, College Park, Maryland								
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 7/10/68		23c. NAME OF CEMETERY OR CREMATORY LOUDON PARK CEMETERY		23d. LOCATION (City or Town) (County) (State) BALTIMORE MARYLAND				
24. FUNERAL DIRECTOR F. GASCH'S SONS		ADDRESS HYATTSVILLE, MD.		25a. REC'D BY REGISTRAR JUL 11 1968		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>				

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

10500

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10509

1. DECEASED-NAME (Type or Print) LEO ROSCOE Mc MATTON			2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> Month <input checked="" type="checkbox"/> Day <input checked="" type="checkbox"/> Year July 6 1968			2b. HOUR M					
3. SEX M		4. RACE W		5. DATE OF BIRTH Feb 7 1906		6. AGE (In years last birthday) 62		7. IF UNDER 1 YEAR <input type="checkbox"/> MONTHS <input type="checkbox"/> DAYS <input type="checkbox"/> IF UNDER 24 HRS. <input type="checkbox"/> HOURS <input type="checkbox"/> MIN			
7a. BIRTHPLACE (State, or foreign country) Wash DC			7b. CITIZEN OF WHAT COUNTRY? USA			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH Prince Georges		
10. CITY OR TOWN OF DEATH Riverdale			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Eugene Leeland Memorial Building			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Electrician			12b. KIND OF BUSINESS OR INDUSTRY Building		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Md			13b. COUNTY Pr Geo			13c. CITY OR TOWN MT Power			13d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		
13e. STREET AND NUMBER 3803-37 St			14. FATHER'S NAME First Roscoe Middle Mc Last mohr			15. MOTHER'S MAIDEN NAME First Wilhelmina Middle Sauer Last Sauer			16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no		
16b. SOCIAL SECURITY NO. 578 05 8347			17. INFORMANT Charles Mc Mohr son of m			ADDRESS 9326 wright			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: 4109 IMMEDIATE CAUSE (a) Coronary Thrombosis DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. Coronary arteriosclerosis (b) Coronary arteriosclerosis DUE TO, OR AS A CONSEQUENCE OF (c)									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH inst		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 4201											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY Month, Day, Year 19 HOUR A.M. P.M.				21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)				21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE Dayton O Watkins				CHIEF MEDICAL EXAMINER <input type="checkbox"/> 7-8-68				22b. DATE SIGNED			
EXAMINER'S NAME (Type) DAYTON O WATKINS				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> 5318 Annapolis Rd			
ADDRESS (Street, city, town, or county) Beadsboro Md				23a. NAME OF CEMETERY OR CREMATORY Ft Lincoln Cemetery				23d. LOCATION (City or Town) (County) (State) Calmar Manor Md			
23b. DATE 7-9-1968				23c. NAME OF CEMETERY OR CREMATORY Ft Lincoln Cemetery				23d. LOCATION (City or Town) (County) (State) Calmar Manor Md			
24. FUNERAL DIRECTOR Valley Funeral Home				ADDRESS MT Rainier Md				25a. REC'D BY REGISTRAR JUL 11 1968			
25b. REGISTRAR'S SIGNATURE Charles Judge				25c. REGISTRAR'S SIGNATURE				25d. REGISTRAR'S SIGNATURE			

10000

UNITED STATES DEPARTMENT OF HEALTH, EDUCATION AND WELFARE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

FOR FILING
HEALTH DEPT.

1

10000

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
CERTIFICATE OF DEATH									
1. DECEASED-NAME (Type or print)			First Middle Last			2a. DATE OF DEATH		2b. HOUR	
Baby Boy Meredith						July Month 9, Day 1968 Year		4:03PM	
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)		IF UNDER 1 YEAR	
Male		Caucasian		July 7, 1968		YRS.		MONTHS DAYS HOURS MIN	
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH			
Maryland		U.S.A.				Prince George's		Md.	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY			
Cheverly		Prince. Geo.Gen'l Hospital		None					
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER	
Maryland		Prince George's		Bowie		YES <input type="checkbox"/> NO <input type="checkbox"/>		12211 Millstream Drive	
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME						
First Middle Last			First Middle Last						
David G. Meredith			Barbara Ewell						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no or unknown			16b. SOCIAL SECURITY NO.		17. INFORMANT Address				
No			None		Hospital Records				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY:									
IMMEDIATE CAUSE (a) <u>Acute Respiratory Distress Syndrome</u>									
DUE TO, OR AS A CONSEQUENCE OF									
(b) <u>Prematurity</u>									
DUE TO, OR AS A CONSEQUENCE OF									
(c)									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)									
<u>Pulmonary Distress syndrome due to Prematurity, 1640 grams; Atelectasis Neonatorum.</u>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
				YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		Yes			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.)					
		HOUR A.M. Month Day Year P.M. 19							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION		Street or R.F.D. No.		City or Town County State	
22a. I certify that (I) (the hospital) attended the deceased from <u>July 7, 1968</u> , to <u>July 9, 1968</u> , that (I) (we) saw the deceased alive on <u>July 9, 1968</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (not) view the body after death.									
22b. SIGNATURE				22c. DATE SIGNED					
<u>John H. Moling, M.D.</u>				July 9, 1968					
22d. PHYSICIAN'S NAME (Type)				22e. ADDRESS		22f. REGISTRAR'S SIGNATURE			
John H. Moling, M.D.				12107 Linden Lane, Bowie, Md. 20715					
23a. BURIAL, CREMATION, REMOVA (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)			
Burial		7-11-1968		New Cathedral Cemetery		Baltimore, Md.			
24. FUNERAL DIRECTOR				25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE			
Nalley Funeral Home Mt. Rainier, Md.				DATE JUL 12 1968		<u>Charles Judge</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR 115 (4)
30M REV. 1/68

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
10502									
CERTIFICATE OF DEATH									
10511									
1. DECEASED-NAME (Type or print)			First Middle Last			2a. DATE OF DEATH Month Day Year		2b. HOUR 1:30 PM	
Michael			F Miller			July 21		1968	
3. SEX MALE		4. RACE White		5. DATE OF BIRTH Jan. 16, 1952		6. AGE (In years last birthday) 16 YRS.		IF UNDER 1 YEAR MONTHS DAYS	
7a. BIRTHPLACE (State or foreign country) Washington D C		7b. CITIZEN OF WHAT COUNTRY? U S A		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Prince George Md.			
10. CITY OR TOWN OF DEATH Cheroverly		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Prince George General		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Student		12b. KIND OF BUSINESS OR INDUSTRY school			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Md		13b. COUNTY Prince George		13c. CITY OR TOWN Landover Hills		13d. INSIDE CITY LIMITS? <input type="checkbox"/> NO <input type="checkbox"/> 13e. STREET AND NUMBER 7403 Parkwood St.			
14. FATHER'S NAME John R. Miller			15. MOTHER'S MAIDEN NAME Ruth D Carter						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) no		16b. SOCIAL SECURITY NO. (If yes give war or dates of service)		17. INFORMANT John R Miller		Address Landover Hills, Md.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Respiratory Acidosis</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Bronchiectasis and Emphysema</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Hypo gamma Globul anemia</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 week 4 Years 16 years	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <u>2922</u>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from <u>June 7, 1968</u> , to <u>July 21, 1968</u> , that (I) (we) lost saw the deceased alive on <u>July 21, 1968</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <u>Thomas G. Maloney MD</u>					22c. DATE SIGNED <u>21 July 68</u>				
22d. PHYSICIAN'S NAME (Type) Thomas G. Maloney, M.D.					22e. ADDRESS 4814 71st Ave. Landover Hills, Md				
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE July 24, 1968		23c. NAME OF CEMETERY OR Washington National			23d. LOCATION (City or Town) (County) (State) Suitland Pro Geo Md		
24. FUNERAL DIRECTOR F. Gasch's Sons Hyattsville, Md.				25a. REC'D BY REGISTRAR DATE JUL 26 1968		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			

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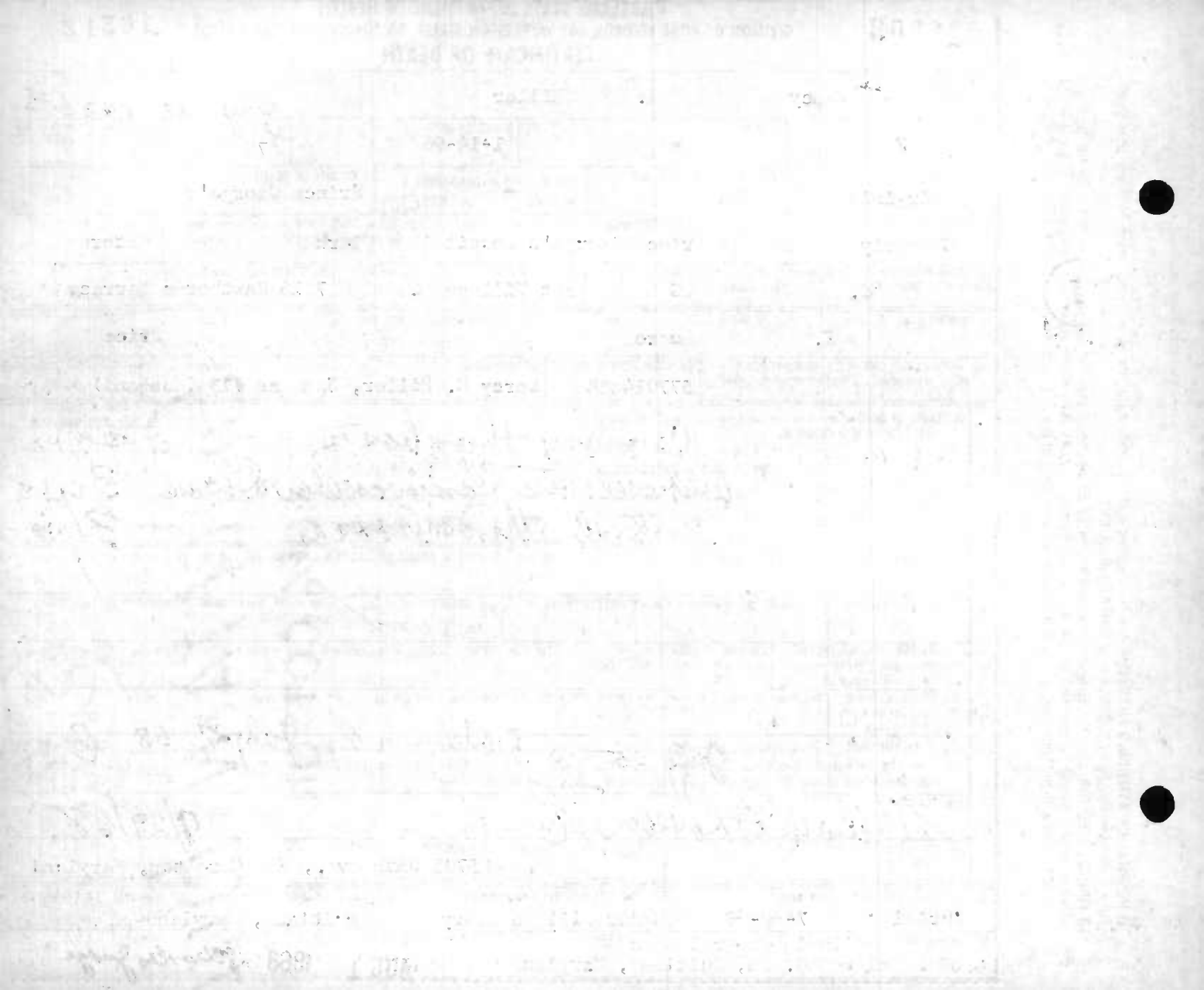
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TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any case, within 72 hours after death.

VR 115 (4)
30M REV. 7-68

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
CERTIFICATE OF DEATH									
1. DECEASED-NAME (Type or print) Nancy			First I. Middle Miller Last			2a. DATE OF DEATH Month July Day 27 Year 1968		2b. HOUR 6:25 AM	
3. SEX F		4. RACE W		5. DATE OF BIRTH 1-14-96		6. AGE (In years last birthday) 72 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (State or foreign country) Virginia		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Prince George's Md.			
10. CITY OR TOWN OF DEATH Cheverly		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Prince George's Hospital		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Clerk		12b. KIND OF BUSINESS OR INDUSTRY Store			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Md.		13b. COUNTY PG		13c. CITY OR TOWN Kent Village		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 7216 Hawthorne Terrace	
14. FATHER'S NAME First E. Middle Moore Last			15. MOTHER'S MAIDEN NAME First Price Middle Price Last						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) NO		16b. SOCIAL SECURITY NO. 577014228		17. INFORMANT Address Percy C. Miller, Same as #13 (Husband)					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary thromboses 4109 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerotic Cardiovascular Disease DUE TO, OR AS A CONSEQUENCE OF (c) Cerebral atherosclerosis								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 hrs 3 yrs 3 yrs	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 4201									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from October 1960 , to July 27, 1968 , that (I) (we) lost saw the deceased alive on July 25, 1968 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE William D. Lessor M.D.		22c. DATE SIGNED 7/29/68		22d. PHYSICIAN'S NAME (Type) 5701 85th Ave., New Carrollton, Maryland					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 7-30-68		23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery		23d. LOCATION (City or Town) (County) (State) Suitland, Maryland			
24. FUNERAL DIRECTOR Wilhelm Funeral Home ADDRESS 4308 Suitland Rd. SE, Suitland, Maryland				25a. REC'D BY REGISTRAR AUG 1 1968		25b. REGISTRAR'S SIGNATURE Charles Judge			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers (pages 1 and 2) and should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR 151
30M REV 7-60

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or print) First Middle Last Jean (nmn) Milligan			2a. DATE OF DEATH Month Day Year July 9 68			2b. HOUR 6, 20AM			
3. SEX Female		4. RACE White		5. DATE OF BIRTH 30 June 1896		6. AGE (In years lost birthday) 72 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (State or foreign country) Scotland		7b. CITIZEN OF WHAT COUNTRY? U. S. A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Prince Georges Md.			
10. CITY OR TOWN OF DEATH Cheverly		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Pr. Geo. Gen. Hosp.		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Housewife		12b. KIND OF BUSINESS OR INDUSTRY --			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland		13b. COUNTY Pr. Geo.		13c. CITY OR TOWN Hyattsville		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 5506 43rd Ave.,	
14. FATHER'S NAME First Middle Last Boyd Bryson				15. MOTHER'S MAIDEN NAME First Middle Last Helen Wilson					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16b. SOCIAL SECURITY NO. (If yes give war or dates of service) 577-26-5434		17. INFORMANT Mr. Alexander Milligan Address 13109 Flint Rock Dr Calverton, Beltsville, Md.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Heart failure. 4129 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerotic Heart Disease. DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) 4201									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (the hospital) attended the deceased from 1962 , to July 9, 1968 , that (I) (we) last saw the deceased alive on July 9, 1968 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE Donald C. Edgren		DEGREE DONALD C. EDGREN		ATTENDING PHYS. XXIX		MED. DIRECTOR <input type="checkbox"/>		STAFF PHYS. <input type="checkbox"/>	
22d. PHYSICIAN'S NAME (Type) DONALD C. EDGREN		22e. ADDRESS Prince George's Plaza, Hyattsville, Md.						22c. DATE SIGNED 7-9-68	
23a. BURIAL, CREMATION, REINTERMENT (Specify) Burial		23b. DATE July 12, 1968		23c. NAME OF CEMETERY OR CREMATORY Ft. Lincoln Cemetery		23d. LOCATION (City or Town) (County) (State) Colmar Manor Pr. Geo. Md.			
24. FUNERAL DIRECTOR Francis Gasch's Sons				ADDRESS Hyattsville, Md.		25a. REC'D BY REGISTRAR DATE JUL 12 1968		25b. REGISTRAR'S SIGNATURE John J. Judge	

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FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-2. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
10505 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 10514									
1. DECEASED-NAME (Type or Print) First Middle Last ROY DANIEL MOORE						2a. DATE KNOWN OF ESTI-DEATH MATED <input checked="" type="checkbox"/> Month Day Year July 7 1968		2b. HOUR 11:15 AM	
3. SEX M	4. RACE W	5. DATE OF BIRTH Jan 17 1913	6. AGE (In years last birthday) 55 YRS.	IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS HOURS MIN	2c. DATE PRONOUNCED DEAD Month Day Year July 7 1968		2d. HOUR 11:15 AM	
7a. BIRTHPLACE (State or foreign country) NC USA		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Prince Georges Md			
10. CITY OR TOWN OF DEATH Cheverly			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Prince Georges Gen Hospital			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Supervisor		12b. KIND OF BUSINESS OR INDUSTRY Railroad	
13a. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) STATE Md			13b. COUNTY Pr Geo		13c. CITY OR TOWN Forestville	13d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	13e. STREET AND NUMBER 3520 - 79th St		
14. FATHER'S NAME First Middle Last Daniel Edgar				15. MOTHER'S MAIDEN NAME First Middle Last Leta Jones					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO			16b. SOCIAL SECURITY NO. 4109		17. INFORMANT wife Rubelle Moore Forestville Md				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Thrombosis 4109 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) instant DUE TO, OR AS A CONSEQUENCE OF (c) PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 4201									
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)				
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE Dayton O Watkins M.D. EXAMINER'S NAME (Type) DAYTON O. WATKINS CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> ADDRESS (Street, city, town, or county) 7-7-68 5318 annapolis Rd Beadenshire Md									
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 7-10-68		23c. NAME OF CEMETERY OR CREMATORY Forest Hill			23d. LOCATION (City or Town) (County) (State) Farmville N.C.		
24. FUNERAL DIRECTOR Lee Funeral Home 300-4 ST NE D.C.				25a. REC'D BY REGISTRAR JUL 10 1968		25b. REGISTRAR'S SIGNATURE Charles Judge			

1001

UNITED STATES DEPARTMENT OF HEALTH
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1001

1001

Name of Deceased		Sex		Age		Date of Death		Place of Death	
John Doe		Male		35		July 10, 1950		New York City	
Cause of Death		Manner of Death		Occupation		Education		Marital Status	
Heart Disease		Natural		Teacher		High School		Married	
Disease or Injury		Immediate Cause		Underlying Cause		Contributing Cause		Other	
Myocardial Infarction		Coronary Atherosclerosis		Hypertension		Smoking		Stress	
Time of Death		Place of Death		Signature of Examiner		Signature of Physician		Signature of Coroner	
10:00 AM		Home		[Signature]		[Signature]		[Signature]	

1001 JUL 10 1950

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
CERTIFICATE OF DEATH									
1. DECEASED-NAME (Type or print)			First	Middle	Last	2a. DATE OF DEATH Month Day Year			2b. HOUR p
Eleanora			Ramona	Moy	July	21	1968	8:50	M
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years lost birthday)		IF UNDER 1 YEAR MONTHS DAYS	
Female		White		August 4, 1887		80 YRS.		IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH			
District of Columbia		United States				Prince George, Md.			
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY			
Hyattsville		Sacred Heart Home		Homemaker					
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER	
Maryland		Prince Geo.		Lanham				7151 Cipriano Road	
14. FATHER'S NAME			First	Middle	Last	15. MOTHER'S MAIDEN NAME			First Middle Last
Theodore			Marsh	Hardy		Mary			Alice Russell
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown)			16b. SOCIAL SECURITY NO.		17. INFORMANT Address				
			219-547-7769		Sacred Heart Home, Hyattsville, Maryland				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)									
PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Uremia</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Indolent Carcinoma of the Thyroid</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Generalized arteriosclerosis</u>									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)									
19a. DATE OF OPERATION									
19b. CONDITION FOR WHICH OPERATION WAS PERFORMED									
20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?									
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)									
21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19									
21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)									
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work									
21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)									
21f. LOCATION Street or R.F.D. No. City or Town County State									
22a. I certify that (I) (this hospital) attended the deceased from <u>6 Jul 1968</u> , to <u>21 Jul 1968</u> , that (I) (we) last saw the deceased alive on <u>21 July 1968</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <u>Thomas G Maloney MD</u> ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>									
22c. DATE SIGNED <u>21 July 68</u>									
22d. PHYSICIAN'S NAME (Type) <u>Thomas G Maloney</u>									
22e. ADDRESS <u>Woodlawn, Md.</u>									
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>									
23b. DATE <u>7/23/68</u>									
23c. NAME OF CEMETERY OR CREMATORY <u>Mt Olivet Cemetery</u>									
23d. LOCATION (City or Town) (County) (State) <u>Washington D C</u>									
24. FUNERAL DIRECTOR ADDRESS <u>F. Gasch's Sons Hyattsville, Md.</u>									
25a. REC'D BY REGISTRAR <u>JUL 25 1968</u>									
25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>									

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FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

10507

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10516

1. DECEASED-NAME (Type or Print)			First Middle Last			2a. DATE KNOWN OF ESTI- DEATH MATED			Month Day Year			2b. HOUR 10:25 P M		
Ethel			Ann			Mudd			7 20 19 68			10:25 P M		
3. SEX	4. RACE	5. DATE OF BIRTH		6. AGE (In years last birthday)	IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN		2c. DATE PRONOUNCED DEAD Month Day Year			2d. HOUR 11:00 P M		
F	W	10 Aug 1942		25 YRS					7 20 68			11:00 P M		
7a. BIRTHPLACE (State or foreign country)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH Prince George Md.					
MD			USA											
10. CITY OR TOWN OF DEATH Clinton			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Clinton Hosp.			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) DOMESTIC			12b. KIND OF BUSINESS OR INDUSTRY HOUSEWIFE					
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Md			13b. COUNTY Prince George			13c. CITY OR TOWN Clinton			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>			13e. STREET AND NUMBER 8522 Delano Drive		
14. FATHER'S NAME First Middle Last JOSEPH MASON JOHNSON			15. MOTHER'S MIDDLE NAME First Middle Last ZULEMIA POSEY JOHNSON											
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No			16b. SOCIAL SECURITY NO. 212-10-7296A			17. INFORMANT JOE MUDD			DORSA WALDORF, MD					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hemorrhagic shock 8121 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Laceration of neck DUE TO, OR AS A CONSEQUENCE OF (c) PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 8164												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Minutes		
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY Month, Day, Year HOUR A.M. 10:25 AM 7 20 19 68			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) Passenger in car involved in collision								
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>			21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) Street			21f. LOCATION Street or R.F.D. No. City or Town County State St. rt. 5 1/2 mile north of Suratts Rd P.G. Md.								
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>														
ACTUAL SIGNATURE EXAMINER'S NAME (Type) John Kehoe, M.D., Riverdale			CHIEF MEDICAL EXAMINER <input type="checkbox"/>			ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			22b. DATE SIGNED 7-21-68		
23a. BURIAL, CREMATION, REMOVAL (Specify)			23b. DATE 7-25-1968			23c. NAME OF CEMETERY OR CREMATORY St. PETERS			23d. LOCATION (City or Town) (County) (State) WALDORF, Charles, Md					
24. FUNERAL DIRECTOR To Untt FUNERAL Home, WALDORF, MD			25a. REC'D BY REGISTRAR DATE JUL 26 1968			25b. REGISTRAR'S SIGNATURE J Charles Judge								

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Joe Wood

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TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. When please remove carbon pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 12 hours after death.

Do not remove with fields approved

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
CERTIFICATE OF DEATH									
1. DECEASED-NAME (Type or print) First Middle Last Charles W. Mullen					2a. DATE OF DEATH July Month 12 Day 1968			2b. HOUR 7:25 A.M.	
3. SEX Male		4. RACE White		5. DATE OF BIRTH May 13 1908		6. AGE (In years lost birthday) 60 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (State or foreign country) Wash, D.C.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Prince George's Md.			
10. CITY OR TOWN OF DEATH Hyattsville		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) 713 Rittenhouse St.		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Bar tender		12b. KIND OF BUSINESS OR INDUSTRY Bar			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland		13b. COUNTY Prince Geo.		13c. CITY OR TOWN Hyattsville		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 713 Rittenhouse St.	
14. FATHER'S NAME First Middle Last Charles Mullen			15. MOTHER'S MAIDEN NAME First Middle Last Nellie Flaherty						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no or unknown Yes		16b. SOCIAL SECURITY NO. 1945		17. INFORMANT Nellie Mullen		Address 713 Rittenhouse St.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinomatosis</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (b) <u>Adenocarcinoma Stomach</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____ PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) <u>151X</u>									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3 yrs
19a. DATE OF OPERATION <u>151X</u>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from _____, 1956, to July 12, 1968, that (I) (we) lost the deceased on July 6, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE John F. Feeney M.D.				DEGREE M.D.		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED July 12, 1968	
22d. PHYSICIAN'S NAME (Type) John F. Feeney M.D.				22e. ADDRESS 1746 K St., N.W., Wash., D.C.					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 7-15-1968		23c. NAME OF CEMETERY OR CREMATORY Mt. Olivet Cemetery		23d. LOCATION (City or Town) (County) (State) Washington, D.C.			
24. FUNERAL DIRECTOR Nalley Funeral Home				ADDRESS Mt. Rainier, Md.		25a. REC'D BY REGISTRAR JUL 16 1968		25b. REGISTRAR'S SIGNATURE J. Charles Judge	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
CERTIFICATE OF DEATH											
1. DECEASED-NAME (Type or print)			First Leo	Middle J.	Last Myzick (Mozdziak)	2a. DATE OF DEATH Month 7 Day 13 Year 1968		2b. HOUR 4:00A			
3. SEX male		4. RACE white		5. DATE OF BIRTH Dec. 19, 1919		6. AGE (In years last birthday) 48 YRS.		IF UNDER 1 YEAR MONTHS 0	IF UNDER 24 HRS. DAYS 0		
7a. BIRTHPLACE (State or foreign country) Pa.		7b. CITIZEN OF WHAT COUNTRY? U S A		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Prince George's Md.					
10. CITY OR TOWN OF DEATH Cheverly			11. NAME OF HOSPITAL OR WHERE DECEASED Prince George General			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Sales Manager		12b. KIND OF BUSINESS OR INDUSTRY Sears			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Md.			13b. COUNTY P.G.		13c. CITY OR TOWN College Park		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 10101 52nd Avenue		
14. FATHER'S NAME First Joseph			Middle Myzick		Last Stella		15. MOTHER'S MAIDEN NAME First Stella			Middle Klimchak	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> (If yes, give date of service) WW II			16b. SOCIAL SECURITY NO. 207-03-8484		17. INFORMANT Address Emma J. Myzick Same as #13						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Sub-ARACHNOID Hemorrhage DUE TO, OR AS A CONSEQUENCE OF (b) Aneurysm DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) 330x											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from 7-10 , 19 68 , to 7-13 , 19 68 , that (I) (we) last saw the deceased alive on 7-12 , 19 68 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE A. Deitz M.D.						DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED 7-13-68			
22d. PHYSICIAN'S NAME (Type) Aaron Deitz, M. D.						22e. ADDRESS Prince George Plaza Hyattsville, Md.					
23a. BURIAL, CREMATION, or other disposition (Specify) Burial			23b. DATE 7/15/68		23c. NAME OF CEMETERY OR CREMATORY Gate of Heaven			23d. LOCATION (City or Town) (County) (State) Silver Spring Montg. Md.			
24. FUNERAL DIRECTOR Francis Gasch's Sons Hyattsville, Maryland						25a. REC'D BY REGISTRAR DATE JUL 17 1968		25b. REGISTRAR'S SIGNATURE Charles Judge			

Franc Gach's Sons Hattsville, Maryland
Gate of Heaven

7/15/68

Burial

Silver Spring P.C. Md.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

10510		DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201				10519			
CERTIFICATE OF DEATH									
1. DECEASED-NAME (Type or print)			First	Middle	Last	2a. DATE OF DEATH Month 4, Day 1968 Year		2b. HOUR 9:05P M	
Leslie			Norfolk						
3. SEX Male		4. RACE Caucasian		5. DATE OF BIRTH 2/28/96 2/28/95		6. AGE (In years last birthday) 73 73 YRS.		IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.
7a. BIRTHPLACE (State or foreign country) Maryland		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Prince George's Md.			
10. CITY OR TOWN OF DEATH Cheverly		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Prince Geo. Gen'l Hospital		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Retired-Pepco		12b. KIND OF BUSINESS OR INDUSTRY			
13a. USUAL RESIDENCE (Where deceased admission) STATE Maryland		13b. COUNTY Prince George's		13c. CITY OR TOWN Seat Pleasant		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 518 67th Place	
14. FATHER'S NAME First Middle Last Samuel Norfolk			15. MOTHER'S MAIDEN NAME First Middle Last Katie Trott						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes		16b. SOCIAL SECURITY NO. 577-05-0342		17. INFORMANT Address #13e Edna Jean Norfolk-daughter Same as					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Nutritional Cirrhosis of the liver with hepatic failure.</u> 5718 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Broncho-pneumonia, right lung.</u> DUE TO, OR AS A CONSEQUENCE OF (c)								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3-6 months 1 month	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 5810									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)				
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State				
22a. I certify that (I) this hospital attended the deceased from Jan 15, 19 68, to July 4, 19 68, that (I) was last saw the deceased alive on July 4, 19 68, and that in (my) own opinion death occurred on the date and hour and from the causes stated above, (I) was (did) not view the body after death.									
22b. SIGNATURE William Brainin DEGREE					ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE/SIGNED 7/5/68		
22d. PHYSICIAN'S NAME (Type) WM BRAININ Peter Duus, M. D.					22e. ADDRESS 6056 Central Ave., Capitol Hgts, Md.				
23a. BURIAL, CREMATION, X UNKNOWN (Specify)		23b. DATE 7/8/68		23c. NAME OF CEMETERY OR CREMATORY Ft. Lincoln Cem		23d. LOCATION (City or Town) (County) (State) Colmar Manor, Md.			
24. FUNERAL DIRECTOR Lee Funeral Home 300-4th St. N.E. Wash. D.C.					25a. REC'D BY REGISTRAR DATE JUL 10 1968		25b. REGISTRAR'S SIGNATURE Charles Judge		

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FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-1. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
Item #8, Film 4404 9/22/68											
MEDICAL EXAMINER'S CERTIFICATE OF DEATH											
1. DECEASED-NAME (Type or Print) First Middle Last David E Norleen						2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> Month Day Year 7 20 1968			2b. HOUR p.m. 11:00		
3. SEX M	4. RACE W	5. DATE OF BIRTH 26 Mar., 89	6. AGE (In years last birthday) 79 YRS.	IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS HOURS MIN.	2c. DATE PRONOUNCED DEAD Month 7 Day 20 Year 19 68			2d. HOUR a.m. 12:01		
7a. BIRTHPLACE (State or foreign country) Minn.		7b. CITIZEN OF WHAT COUNTRY? U. S. A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Prince George Md.					
10. CITY OR TOWN OF DEATH Greenbelt			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Greenbelt Nursing Home			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)			12b. KIND OF BUSINESS OR INDUSTRY		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Md.			13b. COUNTY Prince George Beltsville			13c. CITY OR TOWN YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET AND NUMBER 4510 Yates Rd.		
14. FATHER'S NAME First Middle Last Andred Norleen				15. MOTHER'S MAIDEN NAME First Middle Last Matilda ?							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No			16b. SOCIAL SECURITY NO. (If yes give war or dates of service) 396 03 6781			17. INFORMANT Walter A Norleen			ADDRESS Lanham, Md.		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4129 Heart failure DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } (b) Arteriosclerotic heart disease over 6 months DUE TO, OR AS A CONSEQUENCE OF (c)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 4200 Fracture of neck of right femur 30 April 1968											
19a. DATE OF OPERATION 2 May 1968				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? Intertochantheric fracture rt femur				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input checked="" type="checkbox"/>			21b. TIME OF INJURY Month, Day, Year HOUR P.M. April 30 68			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) Fell getting out of car.					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>			21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) Home			21f. LOCATION Street or R.F.D. No. City or Town County State 4510 Yates Rd., Beltsville, Md.					
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE EXAMINER'S NAME (Type) John Kehoe, M.D., Riverdale, Md.			CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> ADDRESS (Street, city, town, or county)			22b. DATE SIGNED 7-21-68					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial			23b. DATE 7/24/68		23c. NAME OF CEMETERY OR CREMATORY Turlock Memorial Park Ceme.			23d. LOCATION (City or Town) (County) (State) Turlock, Calif.			
24. FUNERAL DIRECTOR F. Gasch's Sons Hyattsville, Md.						25a. REC'D BY REGISTRAR DATE JUL 25 1968		25b. REGISTRAR'S SIGNATURE Charles Judge			

FOR STATE
HEALTH DEPT

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STATE OF NEW YORK
DEPARTMENT OF HEALTH

NAME	...
AGE	...
SEX	...
RACE	...
RELIGION	...
EDUCATION	...
OCCUPATION	...
RESIDENCE	...
DATE OF BIRTH	...
DATE OF DEATH	...
CAUSE OF DEATH	...
PLACE OF DEATH	...
DATE OF BURIAL	...
PLACE OF BURIAL	...
DATE OF EXAMINATION	...
PLACE OF EXAMINATION	...
DATE OF REPORT	...
PLACE OF REPORT	...

JUL 2 1968

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
<div style="display: flex; justify-content: space-between;"> 10512 CERTIFICATE OF DEATH 10521 </div>									
1. DECEASED-NAME (Type or print) First Inez Middle Mae Last O'Dowd						2a. DATE OF DEATH Month 7 Day 13 Year 68		2b. HOUR 4:25A	
3. SEX female		4. RACE white		5. DATE OF BIRTH June 3, 1886		6. AGE (In years last birthday) 82 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (State or foreign country) Maryland		7b. CITIZEN OF WHAT COUNTRY? U S A		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Pr. George's Md.			
10. CITY OR TOWN OF DEATH Cheverly		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Prince George Hospital		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Ret. Saleswoman		12b. KIND OF BUSINESS OR INDUSTRY Store			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Md.		13b. COUNTY P. G.		13c. CITY OR TOWN Hyattsville		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 5600 36th Place	
14. FATHER'S NAME First James Middle Trail Last Trail				15. MOTHER'S MAIDEN NAME First James Middle Trail Last Trail					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) no (If yes give war or dates of service)		16b. SOCIAL SECURITY NO. 579 03 4465		17. INFORMANT Address Paul P. O'Dowd Same as # 13					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4129 Congestive Heart Failure DUE TO, OR AS A CONSEQUENCE OF (b) Arteriosclerotic Heart Disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) Arteriosclerotic Heart Disease DUE TO, OR AS A CONSEQUENCE OF (c) Arteriosclerotic Heart Disease								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a) 4200									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from 5-29 , 19 68 , to 7-13 , 19 68 , that (I) (we) last saw the deceased alive on 7-12 , 19 68 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE A. Deitz		DEGREE MD		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED 7-13-68			
22d. PHYSICIAN'S NAME (Type) Aaron Deitz, M. D.		22e. ADDRESS Prince George Plaza Hyattsville, Md.							
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 7/16/68		23c. NAME OF CEMETERY OR CREMATORY Ft. Lincoln		23d. LOCATION (City or Town) (County) (State) Colmar Manor P. G. Md.			
24. FUNERAL DIRECTOR ADDRESS Francis Gasch's Sons Hyattsville, Md.				25a. REC'D BY REGISTRAR JUL 19 1968		25b. REGISTRAR'S SIGNATURE J. Charles Judge			

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UNITED STATES DEPARTMENT OF AGRICULTURE

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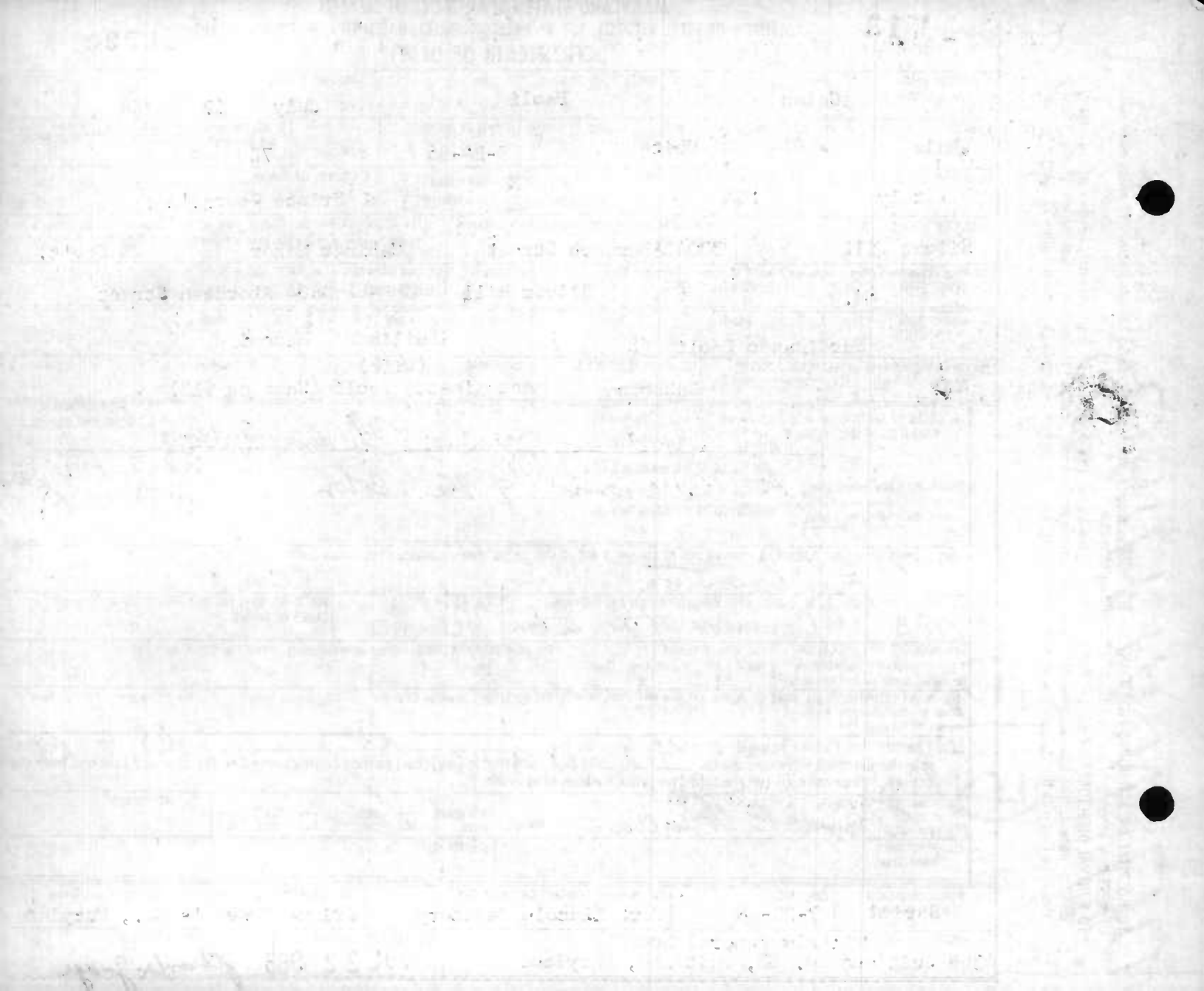
UNITED STATES DEPARTMENT OF AGRICULTURE

UNITED STATES DEPARTMENT OF AGRICULTURE

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. (Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.)

10513										DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										10522																								
CERTIFICATE OF DEATH																																												
1. DECEASED-NAME (Type or print)					First Celso					Middle Paoli					Last Paoli					2a. DATE OF DEATH Month July					Day 17					Year 68					2b. HOUR M									
3. SEX Male					4. RACE White					5. DATE OF BIRTH 5-24-96					6. AGE (In years last birthday) 72					YRS.					IF UNDER 1 YEAR MONTHS					IF UNDER 24 HRS. DAYS					HOURS					MIN.				
7a. BIRTHPLACE (State or foreign country) Italy					7b. CITIZEN OF WHAT COUNTRY? USA					8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>					9. COUNTY OF DEATH Prince George's Md.																													
10. CITY OR TOWN OF DEATH Silver Hill					11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) 3804 Aberdeen Street					12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Cabinet Maker					12b. KIND OF BUSINESS OR INDUSTRY US Gov't.																													
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Md.					13b. COUNTY PG					13c. CITY OR TOWN Silver Hill					13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					13e. STREET AND NUMBER 3804 Aberdeen Street																								
14. FATHER'S NAME First Ferdinando					Middle Paoli					Last Paoli					15. MOTHER'S MAIDEN NAME First Emilia					Middle Mazoni					Last Mazoni																			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> (If yes give war or dates of service)					16b. SOCIAL SECURITY NO. Unknown					17. INFORMANT (Wife) Antoninette Paoli (Same as #13)																																		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>massive gastric bleeding secondary</u> <u>1538</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <u>1538</u> (b) <u>Carcinoma of the colon</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>to</u>																				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>Five years</u>																								
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a) <u>Extreme Emaciation</u>																																												
19a. DATE OF OPERATION <u>1963</u>					19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>Carcinoma of the colon</u>										20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>					20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?																								
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)					21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19					21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 1B.)																																		
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>					21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)					21f. LOCATION Street or R.F.D. No. City or Town County State																																		
22a. I certify that (I) (this hospital) attended the deceased from <u>1964</u> to <u>1968</u> , that (I) (we) lost saw the deceased alive on <u>July 3rd</u> 19 <u>68</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.																																												
22b. SIGNATURE <u>John D. Plencia</u> <u>Edmundo P. Plencia</u>															DEGREE ATTENDING PHYS.					<input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS.					22c. DATE SIGNED																			
22d. PHYSICIAN'S NAME (Type)															22e. ADDRESS																													
23a. BURIAL, CREMATION, REMOVAL					23b. DATE 7-20-68					23c. NAME OF CEMETERY OR CREMATORY Fort Lincoln Cemetery										23d. LOCATION (City or Town) (County) (State) Prince George's Co., Maryland																								
24. FUNERAL DIRECTOR 4308 Suitland Rd. SE, Suitland, Maryland															25a. REC'D BY REGISTRAR DATE JUL 22 1968										25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>																			



FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										
MEDICAL EXAMINER'S CERTIFICATE OF DEATH										
1. DECEASED-NAME (Type or Print) GRETA BELLE PAYICH			2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> Month <input checked="" type="checkbox"/> Day <input checked="" type="checkbox"/> Year July 7 1968			2b. HOUR 2 M				
3. SEX F	4. RACE W	5. DATE OF BIRTH Dec 19 1924	6. AGE (in years last birthday) 39 YRS.	IF UNDER 1 YEAR MONTHS <input type="checkbox"/> DAYS <input type="checkbox"/>	IF UNDER 24 HRS. HOURS <input type="checkbox"/> MIN. <input type="checkbox"/>	2c. DATE PRONOUNCED DEAD Month <input checked="" type="checkbox"/> Day <input checked="" type="checkbox"/> Year 1968		2d. HOUR 4 M		
7a. BIRTHPLACE (State or foreign country) Ohio USA		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Prince Georges Md.				
10. CITY OR TOWN OF DEATH Cheverly			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Prince Georges General			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) attendant		12b. KIND OF BUSINESS OR INDUSTRY Hospital		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE VA			13b. COUNTY Alexandria		13c. CITY OR TOWN Alexandria		13d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		13e. STREET AND NUMBER 6604-8 1st St	
14. FATHER'S NAME First Donald Douglas Middle Ritchie Last Ritchie			15. MOTHER'S MAIDEN NAME First Evelyn Middle Davis Last Davis							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No			16b. SOCIAL SECURITY NO. (If yes give war or dates of service)			17. INFORMANT ADDRESS Hospital Records - Park Police Bldg				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Drowning 954X DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH few minutes										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 975X										
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>			21b. TIME OF INJURY Month, Day, Year 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) Subject stepped off of Pier					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) Mourne		21f. LOCATION Street or R.F.D. No. _____		City or Town _____		County _____ State _____		
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>										
ACTUAL SIGNATURE Dayton O Watkins			M.D. _____			CHIEF MEDICAL EXAMINER <input type="checkbox"/>		22b. DATE SIGNED 7-9-68		
EXAMINER'S NAME (Type) DAYTON O WATKINS			DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			ADDRESS (Street, city, town, or county) _____				
23a. BURIAL, CREMATION, REMOVAL (Specify) _____		23b. DATE July 11, 1968		23c. NAME OF CEMETERY OR CREMATORY Leo Turner Home Washington DC		23d. LOCATION (City or Town) _____ (County) _____ (State) _____				
24. FUNERAL DIRECTOR W.D. Demaine Jr.			ADDRESS 530 1st St			25a. REC'D BY REGISTRAR Charles Judges		25b. REGISTRAR'S SIGNATURE _____		
DATE JUL 12 1968										

THE STATE
OF NEW YORK

(1)

(2)

[Faint, illegible handwritten text, likely bleed-through from the reverse side of the page.]

JUL 13 1901

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form 100-1. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
10515 MEDICAL EXAMINER'S CERTIFICATE OF DEATH									
1. DECEASED-NAME (Type or Print) First Middle Last Rismonda Petrone						2a. DATE KNOWN OF ESTI-DEATH MATED <input checked="" type="checkbox"/> 7-23-68 19 12:10pm		2b. HOUR	
3. SEX Female	4. RACE White	5. DATE OF BIRTH 7-10-1895	6. AGE (In years last birthday) 73 YRS.	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	IF UNDER 24 HRS.	2c. DATE PRONOUNCED DEAD Month Day Year 7 23 68		2d. HOUR 12:15pm	
7a. BIRTHPLACE (State or foreign country) Italy		7b. CITIZEN OF WHAT COUNTRY? U S A		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Prince George's Md.			
10. CITY OR TOWN OF DEATH Cheverly			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Prince George Hospital			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Housewife		12b. KIND OF BUSINESS OR INDUSTRY None	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland			13b. COUNTY Prince George's		13c. CITY OR TOWN Riverdale	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 5505 59th. Avenue	
14. FATHER'S NAME First Middle Last Nichola Casello			15. MOTHER'S MAIDEN NAME First Middle Last Pellegrina Orlanda						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO			16b. SOCIAL SECURITY NO. 579107966B		17. INFORMANT ADDRESS Josephine Petrone same as above				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Heart failure 4120 DUE TO, OR AS A CONSEQUENCE OF Hypertensive arteriosclerotic heart disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF _____ (c) _____								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH minutes	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 443x Diabetes mellitus									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)				
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>									
ACTUAL SIGNATURE John Kehoe MD			M.D. Riverdale, Md.			CHIEF MEDICAL EXAMINER <input type="checkbox"/>		22b. DATE SIGNED 7-24-68	
EXAMINER'S NAME (Type)			ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		ADDRESS (Street, city, town, or county)	
23a. BURIAL, CREMATION REMOVAL (Specify)		23b. DATE 7/26/1968		23c. NAME OF CEMETERY OR CREMATORY Ft Lincoln Cemetery		23d. LOCATION (City or Town) (County) (State) Colmar Manor, Maryland			
24. FUNERAL DIRECTOR Nalley Funeral Home Mt. Rainier, Md.				ADDRESS		25a. REC'D BY REGISTRAR DATE JUL 29 1968		25b. REGISTRAR'S SIGNATURE Charles Judge	

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PHS Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

10516

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10525

1. DECEASED-NAME (Type or Print) James D Poindexter			2a. DATE KNOWN <input checked="" type="checkbox"/> Month 7 Day 26 Year 1968			2b. HOUR 8:00 a m	
3. SEX male	4. RACE white	5. DATE OF BIRTH 5-22-95	6. AGE (In years last birthday) 73 YRS.	IF UNDER 1 YEAR MONTHS 0 DAYS 0	IF UNDER 24 HRS HOURS 0 MIN. 0	2c. DATE PRONOUNCED DEAD Month 7 Day 26 Year 1968	
7a. BIRTHPLACE (State or foreign country) Virginia		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Prince George's Md.	
10. CITY OR TOWN OF DEATH Cheverly		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Prince George's Hospital		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Bookkeeper		12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Md.		13b. COUNTY P.G.		13c. CITY OR TOWN Capitol Hts.		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME Unknown		15. MOTHER'S MAIDEN NAME Unknown		13e. STREET AND NUMBER 209 61st Avenue			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16b. SOCIAL SECURITY NO. 579 12 0735		17. INFORMANT ADDRESS Naomi H. Poindexter Same as 13 abcde			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Heart Failure 4129 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Arteriosclerotic Heart Disease DUE TO, OR AS A CONSEQUENCE OF (c)							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 4200							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY Month, Day, Year HOUR A.M. 19 P.M.		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE John Kehoe		EXAMINER'S NAME (Type) John Kehoe M.D., Riverdale, Maryland		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		22b. DATE SIGNED 7-27-68	
23a. BURIAL, CREMATION, REMOVAL, SPECIFY		23b. DATE 7-29-1968		23c. NAME OF CEMETERY OR CREMATORY Fort Lincoln		23d. LOCATION (City or Town) (County) (State) Prince George Co Md	
24. FUNERAL DIRECTOR Robert A Mattingly		ADDRESS 131 11th St S.E. Washington D.C.		25a. RECD BY REGISTRAR DATE JUL 29 1968		25b. REGISTRAR'S SIGNATURE J Charles Judge	

10333

UNION OF AMERICAN WOMEN'S CLUBS
MEDICAL: JAMES'S CATHEDRAL

10

TOP STAY
HEALTHY



10333

10333

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or print) John J. Poole			2a. DATE OF DEATH Month July , Day 16 , Year 1968			2b. HOUR 1:00A					
3. SEX M		4. RACE N		5. DATE OF BIRTH 12/12/12		6. AGE (In years last birthday) 55		IF UNDER 1 YEAR MONTHS YRS.		IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (State or foreign country) S.C.		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Prince Georges, Md.					
10. CITY OR TOWN OF DEATH Glenn Dale			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Glenn Dale Hospital			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) unknown			12b. KIND OF BUSINESS OR INDUSTRY unknown		
13a. USUAL RESIDENCE (Where deceased admission) STATE Washington, D.C.			13b. COUNTY Washington, D.C.			13c. CITY OR TOWN Washington, D.C.		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 2303 Sherman Ave., N.W.	
14. FATHER'S NAME John Poole			15. MOTHER'S MAIDEN NAME Mattie Smith								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no			16b. SOCIAL SECURITY 4692 579-05-5222			17. INFORMANT decedent					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Massive pulmonary hemorrhage 011.9 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) Pulmonary tuberculosis 1 month										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 10 minutes	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) 002.1											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State							
22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from 7/3/68 , to 7/16/68 , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on 7/16/68 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, <input checked="" type="checkbox"/> (we) (did) (did not) view the body after death.											
22b. SIGNATURE Moe Weiss						DEGREE ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED 7/16/68			
22d. PHYSICIAN'S NAME (Type) Moe Weiss, M.D.						22e. ADDRESS Glenn Dale Hospital, Glenn Dale, Md.					
23a. BURIAL, CREMATION REMOVAL (Specify) Burial		23b. DATE 7/20/68		23c. NAME OF CEMETERY OR CREMATORY Lincoln Memorial Ceme.				23d. LOCATION (City or Town) (County) (State) Maryland			
24. FUNERAL DIRECTOR Stewart						25a. REC'D BY REGISTRAR DATE 22 1968		25b. REGISTRAR'S SIGNATURE Charles Judge			

1

4

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form 1043. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

10518

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10527

1. DECEASED-NAME (Type or Print) Leone Irma Pryor				2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> ESTI. <input type="checkbox"/> Month 7 Day 7 Year 1968		2b. HOUR ab. 11 p.m.	
3. SEX female	4. RACE white	5. DATE OF BIRTH 6-20-06	6. AGE (In years last birthday) 62 YRS.	IF UNDER 1 YEAR MONTHS 0 DAYS 0	IF UNDER 24 HRS. HOURS 0 MIN 0	2c. DATE PRONOUNCED DEAD Month 7 Day 8 Year 1968	
7a. BIRTHPLACE (State or foreign country) VIRGINIA		7b. CITIZEN OF WHAT COUNTRY? U.S.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Prince George's Md.	
10. CITY OR TOWN OF DEATH University Park		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) 4324 Claggett Road		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) RETIRED TEACHER		12b. KIND OF BUSINESS OR INDUSTRY SCHOOL SYSTEM	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Md.		13b. COUNTY P.G.		13c. CITY OR TOWN University Park		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME O. N. LLOYD		15. MOTHER'S MAIDEN NAME ELLA B? LLOYD		13e. STREET AND NUMBER 4324 Claggett Road			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO		16b. SOCIAL SECURITY NO. 213-38-1779-A		17. INFORMANT Cabell N. Pryor Husband ADDRESS Same as above			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Gunshot wound of head 955 X DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 976 X							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY Month, Day, Year HOUR A.M. ab. 11 p.m. 7-7 19 68		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) shot self in head with revolver			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input checked="" type="checkbox"/> NOT WHILE AT WORK		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) home		21f. LOCATION Street or R.F.D. No. City or Town County State 4324 Claggett Road, College Park, P.G., Md.			
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL EXAMINER'S SIGNATURE John Kehoe		EXAMINER'S NAME (Type) John Kehoe M.D., Riverdale, Maryland		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		22b. DATE SIGNED 7-8-68	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 7/10/68		23c. NAME OF CEMETERY OR CREMATORY Ft. Lincoln		23d. LOCATION (City or Town) (County) (State) Colmar Manor, Maryland	
24. FUNERAL DIRECTOR F. Gasch's Sons				ADDRESS Hyattsville, Maryland		25a. REC'D BY REGISTRAR JUL 11 1968	
						25b. REGISTRAR'S SIGNATURE J Charles Judge	

[illegible]

609 11 11

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Items 1 and 3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File Page 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
<div>10519</div> <div>10528</div> <div>Items#7a&7b Film#G4115700</div> <div>MEDICAL EXAMINER'S CERTIFICATE OF DEATH</div>									
1. DECEASED-NAME (Type or Print) First Middle Last George W Ransom						2a. DATE KNOWN OF ESTI-DEATH MATED <input checked="" type="checkbox"/> 7-14-68 199:26pmM		2b. HOUR	
3. SEX Male	4. RACE White	5. DATE OF BIRTH 8-9-1900	6. AGE (In years last birthday) 67 YRS.	IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.	2c. DATE PRONOUNCED DEAD Month Day Year 7 14 68		2d. HOUR 10:04pmM	
7a. BIRTHPLACE (State or foreign country) West Virginia		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		B. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Prince George's Md.			
10. CITY OR TOWN OF DEATH Cheverly			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Prince George Hospital			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Boiler maker		12b. KIND OF BUSINESS OR INDUSTRY U.S. Government	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland			13b. COUNTY Prince George's			13c. CITY OR TOWN Brentwood		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME First Middle Last Joseph J Ransom			15. MOTHER'S MAIDEN NAME First Middle Last Annie Lou Goode			13e. STREET AND NUMBER 4302 Lawrence Street.			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no (If yes give war or dates of service)			16b. SOCIAL SECURITY NO. 577 16 3478		17. INFORMANT ADDRESS Mrs Georgie Ramsom Brentwood, Md.				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Multiple skull fractures 8120 DUE TO, OR AS A CONSEQUENCE OF Trauma - auto accident Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF _____ (c) _____								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) 2194									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY Month, Day, Year HOUR A.M. 9:25pm 7-14-19 68		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) Driver of car involved in collision.					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input checked="" type="checkbox"/> NOT WHILE AT WORK		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) Queen Anne Road and		21f. LOCATION Street or R.F.D. No. Route # 214,		City or Town Maryland		County State	
22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>									
ACTUAL SIGNATURE John Kehoe			EXAMINER'S NAME (Type) John Kehoe MD			CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		22b. DATE SIGNED 7-15-68	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE July 18, 1968		23c. NAME OF CEMETERY OR CREMATORY Ft Lincoln Cemetery		23d. LOCATION (City or Town) (County) (State) Colmar Manor Pro Geo Md.			
24. FUNERAL DIRECTOR F. Gasch's Sons				ADDRESS Hyattsville, Md.		25a. REC'D BY REGISTRAR DATE JUL 19 1968		25b. REGISTRAR'S SIGNATURE J Charles Judge	

10520

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>Prince George</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>MD</u> b. COUNTY <u>Prince George</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Chesley</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Lanham MD Landover</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Prince Geo. Gen. Hosp.</u>				d. STREET ADDRESS <u>3638 Tyrol Dr. Landover, Md.</u>			
3. NAME OF DECEASED (Type or print) <u>William</u> First <u>James</u> Middle <u>Reaves, Sr.</u> Last				4. DATE OF DEATH <u>July 13, 1968</u> Month <u>July</u> Day <u>13</u> Year <u>1968</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>Negro</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>4/10/1931</u>	
9. AGE (In years last birthday) <u>37</u> yrs.		IF UNDER 1 YEAR Months <u>37</u> Days <u>37</u> Hours <u>37</u> Min.		IF UNDER 24 HRS. Months <u>37</u> Days <u>37</u> Hours <u>37</u> Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Occupational Photographer</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>U.S. Govt</u>		11. BIRTHPLACE (State or foreign country) <u>N.C.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>							
13. FATHER'S NAME <u>William James Reaves, Sr.</u>				14. MOTHER'S MAIDEN NAME <u>Elizabeth Murphy</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>579-36-7817</u>		17. INFORMANT <u>Alyce Reaves-Sane AS No. II.</u> Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Nephrotic Syndrome</u> 581X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 591X <u>Cirrhosis of the Liver</u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>7/10</u> 19 <u>68</u> , to <u>7/13</u> 19 <u>68</u> , that I last saw the deceased alive on <u>7/11</u> 19 <u>68</u> , and that death occurred at <u>M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Herbert V. McKnight</u>				ADDRESS (Street, city or town, state) <u>1806 D St NE Wash DC</u> DATE SIGNED <u>7/15/68</u>			
PHYSICIAN'S NAME (Type) <u>Herbert V. McKnight MD</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>7-17-68</u>		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY <u>Harmony</u>		22d. LOCATION (City, town, or county) (State) <u>Highland Park Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>H.S. Woodhugh</u> ADDRESS <u>45 4925 Dune Ave</u>				24. REC'D BY REGISTRAR <u>JUL 17 1968</u> REGISTRAR'S SIGNATURE <u>Judge</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained at the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

2000

101

DECEASED

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

MANNER OF DEATH

AGE

SEX

RACE

EDUCATION

OCCUPATION

RELIGION

DATE OF BIRTH

PLACE OF BIRTH

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

MANNER OF DEATH

AGE

SEX

RACE

EDUCATION

OCCUPATION

RELIGION

DATE OF BIRTH

PLACE OF BIRTH

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

MANNER OF DEATH

AGE

SEX

RACE

EDUCATION

OCCUPATION

RELIGION

DATE OF BIRTH

PLACE OF BIRTH

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
CERTIFICATE OF DEATH									
1. DECEASED-NAME (Type or print) <i>Margaret</i>			First Middle Last <i>Ree N</i>			2a. DATE OF DEATH Month <i>7</i> Day <i>24</i> Year <i>68</i>		2b. HOUR <i>12⁰⁰</i> M	
3. SEX <i>F</i>		4. RACE <i>W</i>		5. DATE OF BIRTH <i>3-9-1884</i>		6. AGE (In years last birthday) <i>84</i> YRS.		IF UNDER 1 YEAR MONTHS OAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (State or foreign country) <i>Ireland</i>		7b. CITIZEN OF WHAT COUNTRY? <i>USA</i>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <i>Prince George</i> Md.			
10. CITY OR TOWN OF DEATH <i>Hagerstown</i>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>4922 La Salle Carroll Manor - Hagerstown - MD</i>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <i>House wife</i>		12b. KIND OF BUSINESS OR INDUSTRY			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <i>DC</i>		13b. COUNTY <i>Wash DC</i>		13c. CITY OR TOWN <i>Wash DC</i>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER <i>220 H Street NE-DC</i>	
14. FATHER'S NAME First Middle Last <i>Patrick Thornhill</i>			15. MOTHER'S MAIDEN NAME First Middle Last <i>Julia Mahoney</i>						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown <i>NO</i>		16b. SOCIAL SECURITY NO. <i>4129</i>		17. INFORMANT <i>John M. Domovic</i>		Address <i>4922 La Salle Rd - Hagerstown MD</i>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cardiac Failure, Congestive</i> DUE TO, OR AS A CONSEQUENCE OF (b) <i>Arteriosclerotic Heart Disease</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i>Generalized Arteriosclerosis</i> CONDITIONS, IF ANY, WHICH GAVE RISE TO IMMEDIATE CAUSE (a), STATING THE UNDERLYING CAUSE LAST. <i>yes</i> <i>years</i>									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>1 day</i>
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <i>4200</i>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <i>19</i>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from <i>5/1</i> , 19 <i>66</i> , to <i>7/24</i> , 19 <i>68</i> , that (I) (two) last saw the deceased alive on <i>7/18</i> , 19 <i>68</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <i>John W Winkler MD</i>				DEGREE <i>MD</i>		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED <i>7/24/68</i>	
22d. PHYSICIAN'S NAME (Type) <i>John W Winkler</i>				22e. ADDRESS <i>5800 10th St Hagerstown MD</i>					
23a. BURIAL CREMATION, REMOVAL (Specify)		23b. DATE <i>7/29/68</i>		23c. NAME OF CEMETERY OR CREMATORY <i>MT. OLIVET</i>		23d. LOCATION (City or Town) (County) (State) <i>WASH D.C.</i>			
24. FUNERAL DIRECTOR <i>HANKON FUNERAL HOME. WASH. DC</i>				ADDRESS		25a. REC'D BY REGISTRAR <i>JUL 26 1968</i>		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	

115-2-102

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transmission permit. Then please remove carbon papers 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

Conclusive
J. H. K. M. V. R. M. C. 16

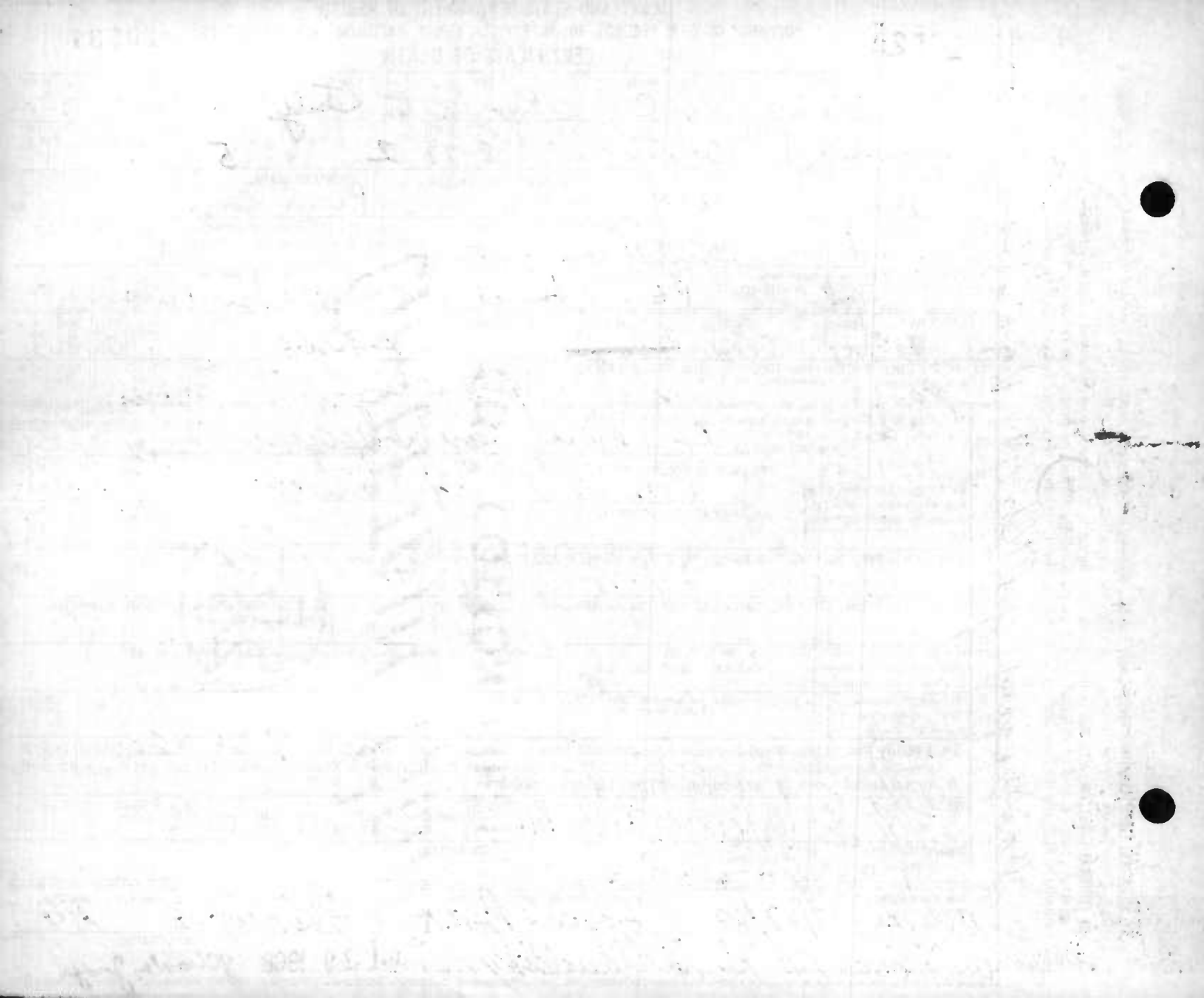
10522

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

10531

CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or print) Elsie First C Middle Remington Last			2a. DATE OF DEATH Month July Day 24 Year 68			2b. HOUR 2:10 P M					
3. SEX female		4. RACE white		5. DATE OF BIRTH 8-27-02		6. AGE (In years last birthday) 85 YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (State or foreign country) md.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Prince Georges Md.					
10. CITY OR TOWN OF DEATH Greenbelt			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Greenbelt Conv. Center			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)			12b. KIND OF BUSINESS OR INDUSTRY		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE md.			13b. COUNTY P.G.		13c. CITY OR TOWN Laurel		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 332 Laurel Ave.		
14. FATHER'S NAME Eber First Crew Middle Remington Last			15. MOTHER'S MAIDEN NAME LAURA First Owens Middle Last								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) no			16b. SOCIAL SECURITY NO. ✓		17. INFORMANT Mr Jesse Remington Address - same						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral embolism 4274 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) cardiac fibrillation DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH minutes 7 years											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) 4331 Cerebral arteriosclerosis											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from 7-23, 1968 to 7-29, 1968 , that (I) (we) lost saw the deceased alive on 7-25, 1968 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE W. C. Wentraub DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>						22c. DATE SIGNED					
22d. PHYSICIAN'S NAME (Type) W. C. WENTRAUB						22e. ADDRESS					
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL			23b. DATE 7/27/68			23c. NAME OF CEMETERY OR CREMATORY LOUON PARK			23d. LOCATION (City or Town) (County) (State) BALTIMORE MD		
24. FUNERAL DIRECTOR DONALDSON F. H. Hunt ADDRESS 1400 E. F. Hunt						25a. REC'D BY REGISTRAR DATE JUL 29 1968			25b. REGISTRAR'S SIGNATURE J. Charles Judge		



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

10523		DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201				10532	
CERTIFICATE OF DEATH							
1. DECEASED-NAME (Type or print) First Middle Last ANNA MARGARET RESAU			2a. DATE OF DEATH 7 Month 11 Day 68 Year			2b. HOUR 5:55 A.M.	
3. SEX Female		4. RACE WHITE		5. DATE OF BIRTH 07/15/98		6. AGE (In years last birthday) 69 YRS.	
7a. BIRTHPLACE (State or foreign country) Md.		7b. CITIZEN OF WHAT COUNTRY? U.S.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Prince Georges Co. Md.	
10. CITY OR TOWN OF DEATH Lanham		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) MAGNOLIA GARDENS NURSING HOME 9104 Good Luck		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Housewife		12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Md.		13b. COUNTY BALTO		13c. CITY OR TOWN Baltimore		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME First Middle Last Morris Resau		15. MOTHER'S MAIDEN NAME First Middle Last Mary Morris		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) (If yes give war or dates of service) no			
16b. SOCIAL SECURITY NO. 214-38-5938		17. INFORMANT Mr. Robt. J. Resau, 7002 Emerson St. 20784				Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiovascular Accident</u> 437.9 DUE TO, OR AS A CONSEQUENCE OF <u>Cerebral Arteriosclerosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Generalized Arteriosclerosis</u> (c) <u>Generalized Arteriosclerosis</u>						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 10 min. 6 years. 10 years.	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) 331X							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19 68		21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from <u>Mar 15, 1968</u> , to <u>Jul 10, 1968</u> , that (I) (we) last saw the deceased alive on <u>9 Jul 1968</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE Thomas A. Maloney				DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED 11 Jul 68	
22d. PHYSICIAN'S NAME (Type) Thomas A. Maloney				22e. ADDRESS 4814 71st Ave. Woodlawn, Hyattsville, Md. 20784			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 7/15/68		23c. NAME OF CEMETERY OR CREMATORY New Cathedral Cemetery		23d. LOCATION (City or Town) (County) (State) Baltimore, Md.	
24. FUNERAL DIRECTOR Witzko, 4101 Edmondson Ave.				ADDRESS 21229		25a. REC'D BY REGISTRAR JUL 16 1968	
						25b. REGISTRAR'S SIGNATURE John J. Judge	

(M)

1945-10-10

1945-10-10

1945-10-10

1945-10-10

FOR STATE
HEALTH DEPT.

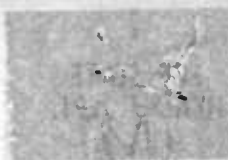
TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

10524

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10533

1. DECEASED-NAME (Type or Print) First Middle Last Francis Wayne Richards			2a. DATE KNOWN OF DEATH ESTIMATED <input type="checkbox"/> Mated <input checked="" type="checkbox"/> 7-29-68 19 7:50pm		2b. HOUR
3. SEX Male	4. RACE White	5. DATE OF BIRTH 10-8-1949	6. AGE (In years last birthday) 18 YRS.	2c. DATE PRONOUNCED DEAD Month 7 Day 30 Year 68 19 1:06pm M	
7a. BIRTHPLACE (State or foreign country) MD.		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
9. CITY OR TOWN OF DEATH Cheverly		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Prince George Hospital		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) WAS ATTENDANT TEXACO	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland		13b. COUNTY Prince George's		13c. CITY OR TOWN Brandywine	
14. FATHER'S NAME First Middle Last FRANK S. Richards		15. MOTHER'S MAIDEN NAME First Middle Last ALICE Hall Richards		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO		16b. SOCIAL SECURITY NO. 213-54-5684		17. INFORMANT ADDRESS FRANK S. Richards Brandywine, MD	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Drowning 9100 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 9298					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?			20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY Month, Day, Year 7:45pm 7-29- 19 68		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) Drowned while swimming	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) Nottingham creek at Windsor Landing, Nottingham, Prince Geo. Co., Md.		21f. LOCATION Street or R.F.D. No. City or Town County State	
22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE John Kehoe		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		22b. DATE SIGNED 7-31-68	
EXAMINER'S NAME (Type) John Kehoe MD Riverdale, Md.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE 8-2-68		23c. NAME OF CEMETERY OR CREMATORY St. Peters	
24. FUNERAL DIRECTOR HUNT Funeral Home		ADDRESS WABORE, MD		25a. RECD BY REGISTRAR Charles Judge	
25b. REGISTRAR'S SIGNATURE Charles Judge		DATE AUG 5 1968		25c. LOCATION (City or Town) (County) (State) WABORE Charles MD.	



639 2-61

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10525

CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or print) George Henry Richards			2a. DATE OF DEATH Month July Day 20 Year 1968			2b. HOUR 8:15AM					
3. SEX Male		4. RACE White Caucasian		5. DATE OF BIRTH Feb. 20, 1922		6. AGE (In years last birthday) 46 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.			
7a. BIRTHPLACE (State or foreign country) Maryland		7b. CITIZEN OF WHAT COUNTRY? U. S. A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Prince George's Md.					
10. CITY OR TOWN OF DEATH Cheverly			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Prince George's Gen. Hosp.			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Tobacco Farming			12b. KIND OF BUSINESS OR INDUSTRY Own Farm		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland			13b. COUNTY Prince Geo.		13c. CITY OR TOWN Mitchellville		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER Mill Branch Road		
14. FATHER'S NAME First Joseph H. Middle Richards			15. MOTHER'S MAIDEN NAME First Margaret Middle - Last Goldsmith			16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, na, or (unknown) No (If yes give war or dates of service) --				16b. SOCIAL SECURITY NO. 213-50-9996	
17. INFORMANT Katherine R. De Priest-Rd. Bowie, Md.			18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Recent Infarction, right basal ganglia & brain stem. DUE TO, OR AS A CONSEQUENCE OF (b) Cerebral arteriosclerosis, marked. DUE TO, OR AS A CONSEQUENCE OF (c) Hypotensive cardiovascular disease.			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 4221											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from July 19, 1968 , to July 20, 1968 , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on July 20, 1968 , and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above. <input checked="" type="checkbox"/> (we) did <input checked="" type="checkbox"/> (did not) view the body after death.											
22b. SIGNATURE DONALD C. EDGREN M.D.			22c. DATE SIGNED 7-20-68			22d. PHYSICIAN'S NAME (Type) DONALD C. EDGREN					
22e. ADDRESS Hattiesville, Miss			23a. BURIAL, CREMATION, REMOVAL (Specify) Burial								
23b. DATE 7/23/68			23c. NAME OF CEMETERY OR CREMATORY St. Paul's Cemetery			23d. LOCATION (City or Town) (County) (State) Baden Pr. Geo Md.					
24. FUNERAL DIRECTOR Ritchie Bros. Upper Marlboro, Md.			25a. REC'D BY REGISTRAR JUL 24 1968			25b. REGISTRAR'S SIGNATURE J. Charles Judge					

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove pages 1 and 2, and should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
10526
10535
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Prince George's	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Upper Marlboro		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Upper Marlboro	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 8305 Rosaryville Road		d. STREET ADDRESS 8305 Rosaryville, Road	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last Le Roy Roger Richardson Jr.		4. DATE OF DEATH Month Day Year July 20 1968	
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 10-16-52
9. AGE (in years last birthday) 15 yrs.		IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY -	
11. BIRTHPLACE (County & State, or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME LeRoy Roger Richardson Jr.		14. MOTHER'S MAIDEN NAME Anna Herriman	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) NO		16. SOCIAL SECURITY NO. None	
17. INFORMANT (Father) LeRoy Roger Richardson, Same as # 2		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 485X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 491X Brain damage - birth injury. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH 14 hrs	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Jan 1963 to 20 July 1968, that (I) (we) last saw the deceased alive on 20 July 1968, and that death occurred at 9:45 A.M. from the causes and on the date stated above.			
22a. SIGNATURE M.D. 22c. PHYSICIAN'S NAME (Type)		22b. DATE SIGNED ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	
22d. ADDRESS			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 7-24-68	
23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery		23d. LOCATION (City, town or county) (State) Suitland, Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE Wilhelm Funeral Home, Suitland, Maryland		25a. REC'D BY REGISTRAR DATE JUL 25 1968	
		25b. REGISTRAR'S SIGNATURE J Charles Judge	

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(M)



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JUL 2 5 1888

RECEIVED JUL 2 5 1888

17-4-05

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove chain papers. Pages 2 and 3 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH										
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										
CERTIFICATE OF DEATH										
1. DECEASED-NAME First Middle Last (Type or print) MARGARET S Ritter					2a. DATE OF DEATH Month Day Year July 19 1968			2b. HOUR MIN 5:30 PM		
3. SEX Female		4. RACE White		5. DATE OF BIRTH 14 Dec 1905		6. AGE (In years last birthday) 62 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN		
7a. BIRTHPLACE (State or foreign country) VA		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH PR. Geo.				
10. CITY OR TOWN OF DEATH COLLEGE PARK			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) 4910 Blackfoot Rd			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Housewife		12b. KIND OF BUSINESS OR INDUSTRY None		
13a. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) STATE Md.			13b. COUNTY Pr Geo		13c. CITY OR TOWN Same		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER Same	
14. FATHER'S NAME First Middle Last Herman H.F. SCHUTT			15. MOTHER'S MAIDEN NAME First Middle Last Helen Strutz			16. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown (If yes give war or dates of service)				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown			16b. SOCIAL SECURITY NO. 918-1475E			17. INFORMANT Adeline M TRUEMAN (Sister) 918-1475E Wash DC Phone 417-21				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4120 Cerebral Thrombosis DUE TO, OR AS A CONSEQUENCE OF (b) Hypertensive arteriosclerotic Cerebral Vascular disease DUE TO, OR AS A CONSEQUENCE OF (c) Arterio-sclerotic Heart Disease								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) 4200 Diabetes Mellitus										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.)						
21d. INJURY OCCURRED White <input type="checkbox"/> Nat while <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No.		City or Town		County State		
22a. I certify that (I) (this hospital) attended the deceased from July 19 1968, to July 19 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE W.L. Etienne				DEGREE ATTENDING PHYS.		MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED 7-19-68		
22d. PHYSICIAN'S NAME (Type) W.L. ETIENNE				22e. ADDRESS College Park, Md.						
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE July 22, 1968		23c. NAME OF CEMETERY OR CREMATORY Ft Lincoln Cemetery		23d. LOCATION (City or Town) (County) (State) Colmar Manor Pro Geo Md.				
24. FUNERAL DIRECTOR F. Gasch's Sons				ADDRESS Hyattsville, Md		25a. RECEIVED BY REGISTRAR JUL 23 1968		25b. REGISTRAR'S SIGNATURE Johnas Judge		

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WATER JULY 1902
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MAY 1902
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WATER JULY 1902
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COLLEGE PARK
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1400 100
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FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-1. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
MEDICAL EXAMINER'S CERTIFICATE OF DEATH											
1. DECEASED NAME (Type or Print) First Middle Last EDMUND PEARSON Robinson						2a. DATE KNOWN OF DEATH Month Day Year July 5 1968			2b. HOUR M 8		
3. SEX M		4. RACE W		5. DATE OF BIRTH July 17 1876		6. AGE (in years last birthday) YRS. MONTHS DAYS 91		IF UNDER 1 YEAR HOURS MIN. 24		2c. DATE PRONOUNCED DEAD Month Day Year July 5 1968	
7a. BIRTHPLACE (State or foreign country) England		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Prince Georges Md.					
10. CITY OR TOWN OF DEATH Cheverly				11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Prince Georges General				12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Retired		12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Md				13b. COUNTY Prince Georges		13c. CITY OR TOWN Beltsville		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 5512-23 PL	
14. FATHER'S NAME First Middle Last unknown						15. MOTHER'S MAIDEN NAME First Middle Last PEARSON					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no				16b. SOCIAL SECURITY NO.		17. INFORMANT Son-in-law Michael Steel		ADDRESS 5512-23 PL Beltsville Md			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac decompensation DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) Arteriosclerotic heart disease DUE TO, OR AS A CONSEQUENCE OF (c) Generalized arteriosclerosis										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 4129 years	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 4200											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)				21f. LOCATION Street or R.F.D. No.		City or Town		County State	
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE Dayton O Watkins				M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
EXAMINER'S NAME (Type) DAYTON O WATKINS				ADDRESS (Street, city, town, or county) 3318 Annapolis Rd		22b. DATE SIGNED 7-6-68		22c. REGISTRAR'S SIGNATURE J Charles Judge			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 7/9/68		23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery		23d. LOCATION (City or Town) (County) (State) Suitland, Maryland		24. FUNERAL DIRECTOR Robert E. Wilhelm Funeral Home 4308 Suitland Road, Suitland, Maryland			
25a. REC'D BY REGISTRAR JUL 11 1968						25b. REGISTRAR'S SIGNATURE J Charles Judge					

Two for one Film #G402 7/17/68 kk

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers - pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
CERTIFICATE OF DEATH									
1. DECEASED-NAME (Type or print)			First Middle Last			2a. DATE OF DEATH		2b. HOUR	
Keith Adrian Robinson						July 3, 1968		5:20 A M	
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years lost birthday)		7. IF UNDER 1 YEAR MONTHS DAYS	
Male		Caucasian		Feb. 20, 1962		6 YRS			
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH		12b. KIND OF BUSINESS OR INDUSTRY	
Maryland		U.S.A.				Prince George's		Md.	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)					
Cheverly		Prince Geo.Gen'l Hospital		school					
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER	
Maryland		Howard		Lanham		YES <input type="checkbox"/> NO <input type="checkbox"/>		Box 132	
14. FATHER'S NAME First Middle Last			15. MOTHER'S MAIDEN NAME First Middle Last						
Adrian C. Robinson			Betty Jane Linder						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown (If yes give war or dates of service)			16b. SOCIAL SECURITY NO.		17. INFORMANT Address				
no					Adrian C. Robinson - Above				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>respiratory arrest</u>									
743.2 DUE TO, OR AS A CONSEQUENCE OF (b) <u>intracerebellar hemorrhage</u>									37 days
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO, OR AS A CONSEQUENCE OF (c) <u>vascular malformation of cerebellum</u>									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)									
753.1									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (the registrar) attended the deceased from May 26, 1968, to July 3, 1968, that (I) (we) last saw the deceased alive on July 3, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <u>Ruth K. Jakoby</u> MD				22c. DATE SIGNED <u>8-3-68</u>					
22d. PHYSICIAN'S NAME (Type) <u>Ruth K. Jakoby, M. D.</u>				22e. ADDRESS <u>6401 Landover Rd., Cheverly, Md. 20785</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE <u>7-6-68</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Emmanuel Cem.</u>		23d. LOCATION (City or Town) (County) (State) <u>Scaggville Md.</u>			
24. FUNERAL DIRECTOR <u>Be Witt Donaldson</u>				ADDRESS <u>Lanham, Md</u>		25a. REC'D BY REGISTRAR <u>Charles J. Jones</u>		25b. REGISTRAR'S SIGNATURE <u>Charles J. Jones</u>	
				DATE <u>JUL - 9 1968</u>					

THE UNIVERSITY OF CHICAGO
DIVISION OF THE PHYSICAL SCIENCES
DEPARTMENT OF CHEMISTRY
JAN 10 1963

TO: Mr. J. H. Drenth
FROM: Mr. J. H. Drenth
SUBJECT: [illegible]

[illegible handwritten text]

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 should be filed with the State Dept. at Health prior to burial, cremation, or removal, and in any event, within 48 hours after death.

VR 15-1-68
30M REV. 1-7-68

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or print) <i>Helen Irene Powe</i>		2a. DATE OF DEATH Month <i>7</i> Day <i>10</i> Year <i>1968</i>		2b. HOUR <i>5:15 A.M.</i>
3. SEX <i>F</i>	4. RACE <i>white</i>	5. DATE OF BIRTH <i>Apr. 19, 1882</i>	6. AGE (in years last birthday) <i>86</i> YRS.	IF UNDER 1 YEAR MONTHS IF UNDER 24 HRS. DAYS HOURS MIN.
7a. BIRTHPLACE (State or foreign country) <i>Canada</i>	7b. CITIZEN OF WHAT COUNTRY? <i>U.S.</i>	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH <i>Prince George</i> Md.	
10. CITY OR TOWN OF DEATH <i>Adelphi</i>	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>3120 Powder Mill Rd. Takoma Park</i>	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <i>Tailor/ess</i>	12b. KIND OF BUSINESS OR INDUSTRY <i>DRESS MAKING</i>	
13a. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) STATE <i>Md.</i>	13b. COUNTY <i>Prince George</i>	13c. CITY OR TOWN <i>Takoma Park</i>	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET AND NUMBER <i>7214 Garland Ave</i>
14. FATHER'S NAME First <i>George</i> Middle <i>-</i> Last <i>Dalmage</i>	15. MOTHER'S MAIDEN NAME First <i>Emme</i> Middle <i>-</i> Last <i>Breckenridge</i>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown <i>No</i> (If yes give war or dates of service)	16b. SOCIAL SECURITY NO. <i>554-01-62300</i>	17. INFORMANT Address <i>Mrs. Grace Behabetz 7214 Garland Ave.</i>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Coronary Arteriosclerosis - left ventricular failure</i> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Arteriosclerotic coronary vascular disease</i> DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>3 yrs.</i> <i>12 yrs.</i>				
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <i>4221</i>				
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <i>19</i>	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)		
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No. City or Town County State		
22a. I certify that (I) (this hospital) attended the deceased from <i>11-3</i> , 19 <i>65</i> , to <i>7-10</i> , 19 <i>68</i> , that (I) (we) last saw the deceased alive on <i>7-3</i> , 19 <i>68</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.				
22b. SIGNATURE <i>R.D. Bauer M.D.</i>	DEGREE <i>M.D.</i>	ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22c. DATE SIGNED <i>7-10-68</i>	
22d. PHYSICIAN'S NAME (Type) <i>R.D. BAUER</i>	22e. ADDRESS <i>2513 Buck Lodge Rd. Adelphi, Md.</i>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Cremation</i>	23b. DATE <i>July 12, 1968</i>	23c. NAME OF CEMETERY OR CREMATORY <i>East Lincoln Crematory</i>	23d. LOCATION (City or Town) (County) <i>Prince George Co. Md.</i>	
24. FUNERAL DIRECTOR <i>Warner C. Pumphrey, Inc.</i>	ADDRESS <i>8434 Georgia Ave. Silver Spring, Md.</i>	25a. REC'D BY REGISTRAR <i>JUL 15 1968</i>	25b. REGISTRAR'S SIGNATURE <i>J. Charles Judge</i>	

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10531

CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or print) ABRAHAM		First Middle Last D. RUCHWARGER, M.D.		2a. DATE OF DEATH Month Day Year July 8, 1968		2b. HOUR 12 Noon	
3. SEX MALE		4. RACE CAUCASIAN		5. DATE OF BIRTH SEPT. 1, 1912		6. AGE (In years last birthday) 55 YRS.	
7a. BIRTHPLACE (State or foreign country) RUSSIA		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH PRINCE GEORGES Md.	
10. CITY OR TOWN OF DEATH OXON HILL		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) 7 MELMARA DRIVE		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) PHYSICIAN		12b. KIND OF BUSINESS OR INDUSTRY MEDICAL	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Md.		13b. COUNTY P. Georges		13c. CITY OR TOWN OXON HILL		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
13e. STREET AND NUMBER 7 MELMARA DRIVE		14. FATHER'S NAME First Middle Last EMANUEL RUCHWARGER		15. MOTHER'S MAIDEN NAME First Middle Last Unknown			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) NO		16b. SOCIAL SECURITY NO. *****		17. INFORMANT Address ZDENKA RUCHWARGER (same as 13e.)			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary occlusion 4109 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Intense chronic heart disease DUE TO, OR AS A CONSEQUENCE OF (c)						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 15 min 0 years	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) 4201							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from June, 1966 to July 8, 1968 , that (I) (we) last saw the deceased alive on July 8, 1968 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE Herbert Wisotsky DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>				22c. DATE SIGNED 7-8-68			
22d. PHYSICIAN'S NAME (Type) HERBERT WISOTSKY, M.D.				22e. ADDRESS 101 Audry La.; Oxon Hill, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE 7/12/68		23c. NAME OF CEMETERY OR CREMATORY Israel Israel		23d. LOCATION (City or Town) (County) (State)	
24. FUNERAL DIRECTOR ADDRESS Bernard Danzansky & Sons Washington, D.C.							
25a. REC'D BY REGISTRAR JUL 10 1968				25b. REGISTRAR'S SIGNATURE J. Charles Juge			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers (pages 1 and 2) should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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STATE OF NEW YORK

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10532

CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or print) ANTONIO			First Middle Last			2a. DATE OF DEATH JULY 6 1968			2b. HOUR 11:30 PM		
3. SEX MALE			4. RACE WHITE			5. DATE OF BIRTH APRIL 12, 1880			6. AGE (In years last birthday) 88 YRS.		
7a. BIRTHPLACE (State or foreign country) NUSCO, ITALY			7b. CITIZEN OF WHAT COUNTRY? U.S.			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH PRINCE GEORGE Md.		
10. CITY OR TOWN OF DEATH DISTRICT HEIGHTS			11. NAME OF HOSPITAL OR INSTITUTION (If nat in hospital give street address) CATHOLIC SCHOOL			12a. USUAL OCCUPATION (Kind of work done during most of working life, when engaged) GOV.			12b. KIND OF BUSINESS OR INDUSTRY		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE MARYLAND			13b. COUNTY P.G.			13c. CITY OR TOWN DIST. HEIGHTS			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
13e. STREET AND NUMBER 3326 SENATOR AVENUE			14. FATHER'S NAME ANATO			15. MOTHER'S MAIDEN NAME TERESA			15. MOTHER'S MAIDEN NAME PASTORO		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, nd, or unknown) NO (If yes give war or dates of service)			16b. SOCIAL SECURITY NO.			17. INFORMANT E. MICHAEL ROLL			Address 3201 LUANA AVE		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: 4129 IMMEDIATE CAUSE (a) CEREBRAL HEMORRHAGE DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) ARTERIO-SCLEROTIC CARDIO VASCULAR DISEASE DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 week 10 YEARS											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (o) 4221											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from 1958 to JULY 6, 1968 , that (I) (we) last saw the deceased alive on JULY 6, 1968 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE Benjamin S. Pearson M.D.			DEGREE			ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			22c. DATE SIGNED 7-6-68		
22d. PHYSICIAN'S NAME (Type) BENJAMIN S. PEARSON M.D.			22e. ADDRESS 6106 OLD SILVER HILL ROAD WASH. DC 20028								
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL			23b. DATE 7-9-1968			23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery			23d. LOCATION (City or Town) (County) (State) Suitland PG Maryland		
24. FUNERAL DIRECTOR Robert E. Wilhelm Funeral Home 4308 Suitland Road Suitland Maryland						25a. REC'D BY REGISTRAR DATE JUL 11 1968			25b. REGISTRAR'S SIGNATURE Charles Judge		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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10533

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

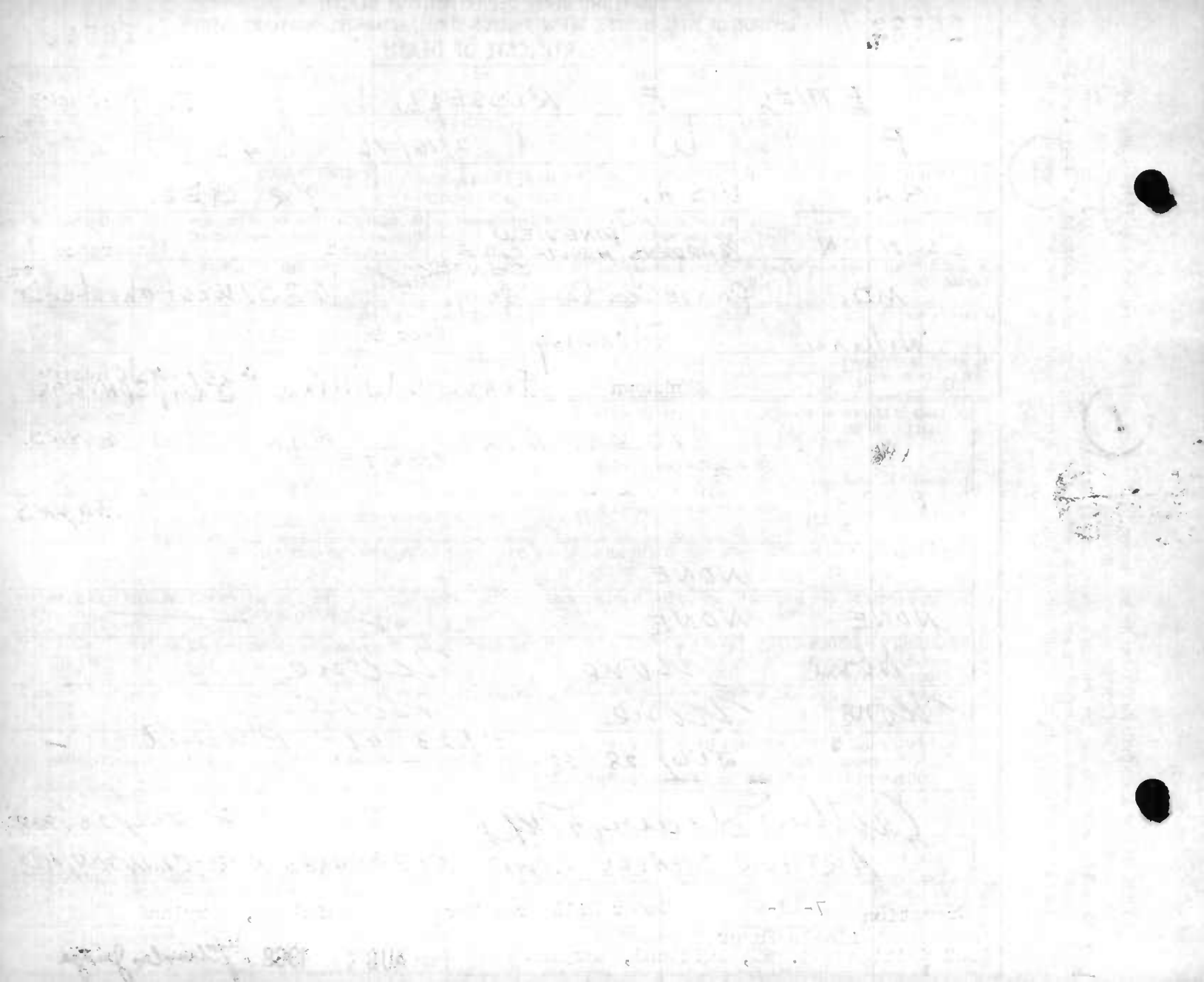
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10542

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or print) ETHEL F. RUSSELL			2a. DATE OF DEATH Month JULY Day 28 Year 1968			2b. HOUR 10:52 AM					
3. SEX F		4. RACE W		5. DATE OF BIRTH 2/16/76		6. AGE (In years last birthday) 92 YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (State or foreign country) GA.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH PR. GEO.					
10. CITY OR TOWN OF DEATH CLINTON			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) PINEVIEW GARDEN'S HEALTH CARE			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Agent			12b. KIND OF BUSINESS OR INDUSTRY Insurance		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE MD.			13b. COUNTY Prince Geo. Camp Springs			13c. CITY OR TOWN CLINTON		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 6257 West Chester Dr.	
14. FATHER'S NAME First William Middle Last Flemming			15. MOTHER'S MAIDEN NAME First Georgia Middle Williams Last								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> or (unknown) (If yes give war or dates of service)			16b. SOCIAL SECURITY NO. Unknown			17. INFORMANT Frances William Address 6257 West Chester CAMP SPRINGS					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) MYOCARDIAL INFARCTION 4109 DUE TO, OR AS A CONSEQUENCE OF ACUTE Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) ARTERIO SCLEROTIC HEART DISEASE DUE TO, OR AS A CONSEQUENCE OF 30 YRS (c)											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) 4201 NONE											
19a. DATE OF OPERATION NONE			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED NONE			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH (If either, notify medical examiner) NONE			21b. TIME OF INJURY HOUR A.M. Month Day Year NONE			21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 1B.) NONE					
21d. INJURY OCCURRED While <input type="checkbox"/> at home <input type="checkbox"/> at work NONE			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) NONE			21f. LOCATION Street or R.D. No. City or Town County State NONE					
22a. I certify that (this hospital) attended the deceased from 5/23, 1962 to Present , that (I) (we) last saw the deceased alive on JULY 28, 1968 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE Arthur Shaver Jr.						22c. DATE SIGNED JULY 28, 1968			22d. PHYSICIAN'S NAME (Type) ARTHUR SHAVER JR.		
23a. BURIAL, CREMATION, REMOVAL (Specify) Cremation			23b. DATE 7-29-68			23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Crematory			23d. LOCATION (City or Town) (County) (State) Suitland, Maryland		
24. FUNERAL DIRECTOR Wilhelm Funeral Home 4308 Suitland Rd. SE, Suitland, Maryland						25a. REC'D BY REGISTRAR AUG 1 1968			25b. REGISTRAR'S SIGNATURE Charles Judge		

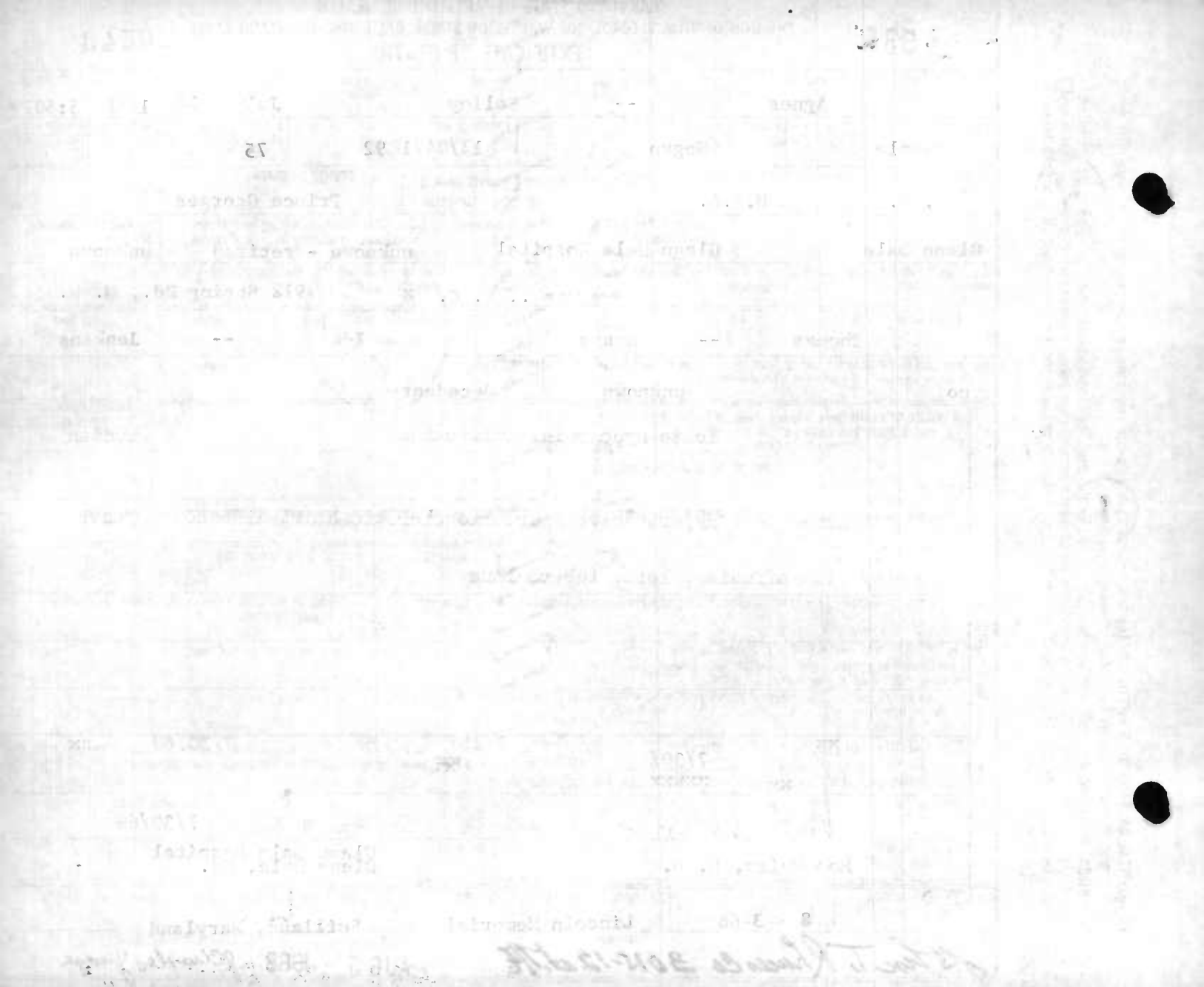


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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VR A15 (4)
30M REV. 1-58

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
16534									
10543									
CERTIFICATE OF DEATH									
1. DECEASED-NAME (Type or print)			First Middle Last			2a. DATE OF DEATH		2b. HOUR	
Agnes			-- Salley			Month Day Year July 30 1968		5:50 P M	
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
Female		Negro		12/04/1892		75 YRS.			
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH			
S. C.		U.S.A.				Prince Georges Md.			
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY			
Glenn Dale		Glenn Dale Hospital		unknown - retired		unknown			
13a. USUAL RESIDENCE (Where deceased admission) STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER	
		13b. COUNTY		Wash., D. C.				912 Spring Rd., N. W.	
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME						
First Middle Last			First Middle Last						
Thomas -- Evans			Ida -- Jenkins						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown			16b. SOCIAL SECURITY NO.			17. INFORMANT			
no			unknown			Decedent			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY:								sudden	
IMMEDIATE CAUSE (a) 4100 Acute myocardial infarction									
DUE TO, OR AS A CONSEQUENCE OF									
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 4201									
(b) DUE TO, OR AS A CONSEQUENCE OF								years	
Hypertensive & arteriosclerotic heart disease									
(c)									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
Pleurisy with effusion, left, tuberculous									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
					YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
21a. ACCIDENT WAS UNDERLYING		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
<input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		HOUR A.M. Month Day Year P.M. 19							
21d. INJURY OCCURRED		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION					
While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>				Street or R.F.D. No. City or Town County State					
22a. I certify that (we) (this hospital) attended the deceased from 7/26/1968, to 7/30/1968, that (we) last saw the deceased alive on 7/30/1968, and that in (our) (our) opinion death occurred on the date and hour and from the causes stated above, (we) (we) (did not see) view the body after death.									
22b. SIGNATURE				DEGREE		ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED	
Moe Weiss								7/30/68	
22d. PHYSICIAN'S NAME (Type)				22e. ADDRESS					
Moe Weiss, M. D.				Glenn Dale Hospital Glenn Dale, Md.					
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)			
8 - 3-68		8 - 3-68		Lincoln Memorial		Suttlund, Maryland			
24. FUNERAL DIRECTOR				25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE			
John T. Rhines Co 3015-12 St. N.E.				AUG 5 1968		Charles Judge			



10533

10544

CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or print) Baby			First Girl			Last Sams			2a. DATE OF DEATH July Month 7 , Day 1968 Year			2b. HOUR 2:50P M			
3. SEX Female			4. RACE Caucasian			5. DATE OF BIRTH July 7, 1968			6. AGE (In years last birthday) YRS.			IF UNDER 1 YEAR MONTHS		IF UNDER 24 HRS. HOURS MIN	
7a. BIRTHPLACE (State or foreign country) Maryland			7b. CITIZEN OF WHAT COUNTRY? U.S.A.			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH Prince George's			Md.			
10. CITY OR TOWN OF DEATH Cheverly			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Prince Geo.Gen'l Hospital			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) None			12b. KIND OF BUSINESS OR INDUSTRY None						
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland			13b. COUNTY Prince George's			13c. CITY OR TOWN Mt. Rainier			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>			13e. STREET AND NUMBER 412 36th St.			
14. FATHER'S NAME First George			Middle Sams			Last Wanda G. Graham			15. MOTHER'S MAIDEN NAME First Wanda G. Graham			Middle Wanda G. Graham			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) No			(If yes give war or dates of service) None			16b. SOCIAL SECURITY NO. None			17. INFORMANT Prince George's Hospital Records			Address			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 7761 atelectasis DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost Respiratory Distress Syndrome (b) Pneumonia DUE TO, OR AS A CONSEQUENCE OF (c)												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (c) 7625															
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?						
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)									
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State									
22a. I certify that 7/7 (this hospital) attended the deceased from 7/7 , 19 68 , to 7/7 , 19 68 , that we (we) last saw the deceased alive on 7/7 , 19 68 , and that in our (our) opinion death occurred on the date and hour and from the causes stated above, we (we) (did, did not) view the body after death.															
22b. SIGNATURE John W. Perkins			DEGREE			ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>			22c. DATE SIGNED 7/8/68						
22d. PHYSICIAN'S NAME (Type) John W. Perkins, M. D.			22e. ADDRESS Prince Geo. General Hospital, Cheverly,												
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial			23b. DATE 7-11-1968			23c. NAME OF CEMETERY OR CREMATORY Mt Olivet Cemetery			23d. LOCATION (City or Town) (County) (State) Washington, D.C. Maryland						
24. FUNERAL DIRECTOR Nalley Funeral Home Mt. Rainier, Md.			ADDRESS			25a. REC'D BY REGISTRAR DATE JUL 12 1968			25b. REGISTRAR'S SIGNATURE Charles Judge						

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

81-19239

624

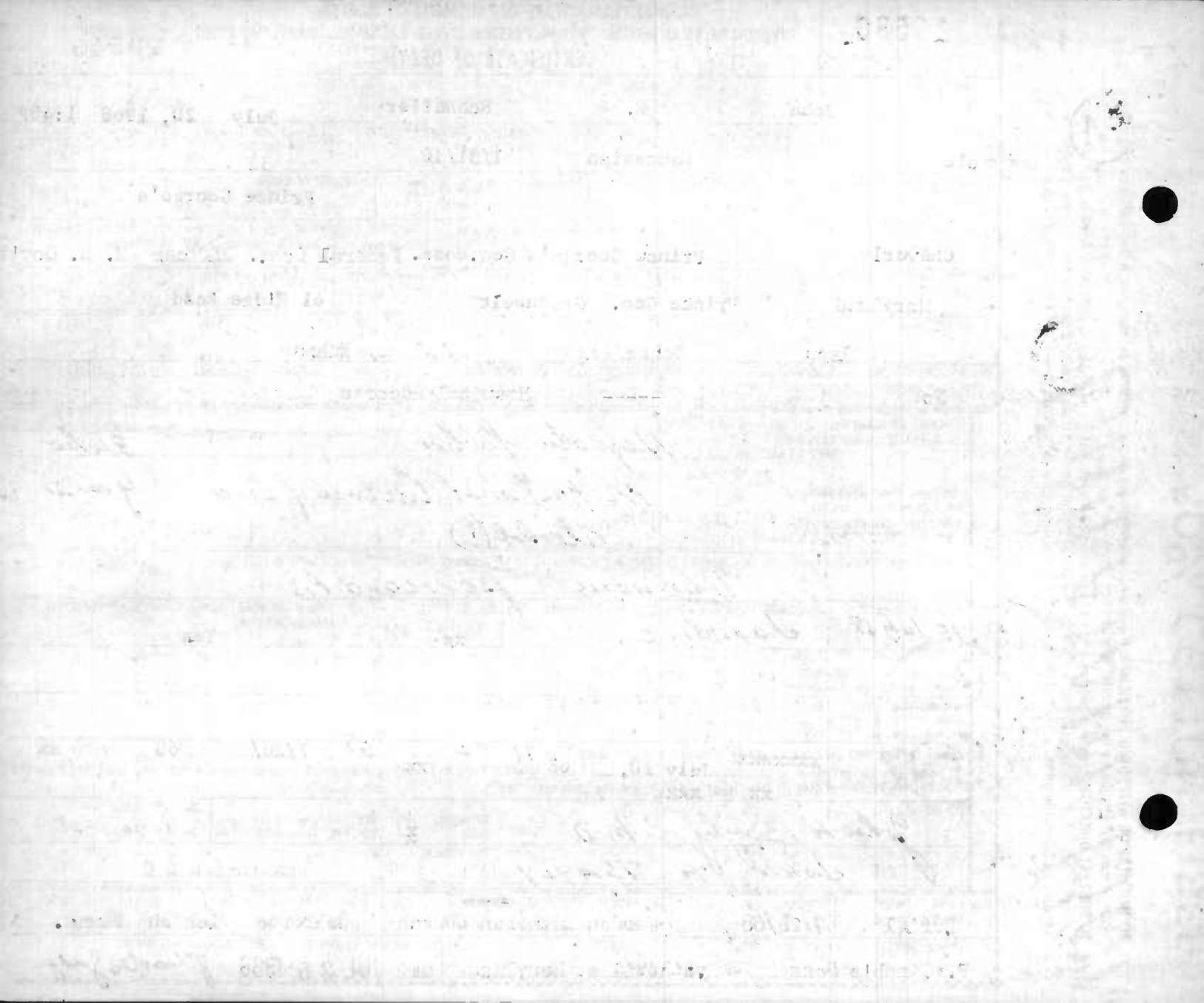
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1017-776

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

10536		MARYLAND STATE DEPARTMENT OF HEALTH		DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201		10545			
Item#8, Film G403		7/31/68 km		CERTIFICATE OF DEATH					
1. DECEASED-NAME (Type or print)			First	Middle	Last	2a. DATE OF DEATH Month Day Year		2b. HOUR	
John			E.	Schaeffer	July 20, 1968		1:40 PM		
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN	
male		Caucasian		1/31/16		52 YRS.			
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH			
Pa		U S A.				Prince George's Md.			
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b. KIND OF BUSINESS OR INDUSTRY			
Cheverly		Prince George's Gen. Hosp.		Federal Comm. Officer		U. S. Gov't			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)		13b. CITY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER	
STATE Maryland		County Prince Geo.		Greenbelt				61 Ridge Road	
14. FATHER'S NAME			First	Middle	Last	15. MOTHER'S MAIDEN NAME			First Middle Last
Wilson			Schaeffer	Alice Kuhns					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown			16b. SOCIAL SECURITY NO.		17. INFORMANT				Address
No			-----		Hospital Records				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Hepatic failure</u> 5710 DUE TO, OR AS A CONSEQUENCE OF (b) <u>Nutritional Anoxia of Liver</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>alcohol (?)</u>								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 7 weeks years	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 5811 <u>Fibrinous pericarditis</u>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
15 July 68		Jaundice		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		Yes			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from 7/12/68, to 7/20/1968, that (I) was saw the deceased alive on July 20, 1968, and that in (my) her opinion death occurred on the date and hour and from the causes stated above, (I) do (did) not view the body after death.									
22b. SIGNATURE John H. Bayly M.D.				DEGREE		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED July 20, 1968	
22d. PHYSICIAN'S NAME (Type) John H. Bayly				22e. ADDRESS Washington D C					
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)			
Burial		7/24/68		Jordan Lutheran Church		Walberts Lehigh Penna.			
24. FUNERAL DIRECTOR				ADDRESS		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	
F. Gasch's Sons				Hyattsville, Maryland		DATE JUL 25 1968		J Charles Judge	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

10537										DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										10546																																							
1. DECEASED-NAME (Type or print)										2a. DATE OF DEATH										2b. HOUR																																							
First Middle Last										Month Day Year										Hour Min. PM																																							
Mary Catherine Schwartz										7 14 68										6 05 PM																																							
3. SEX										4. RACE										5. DATE OF BIRTH										6. AGE (In years last birthday)										IF UNDER 1 YEAR										IF UNDER 24 HRS.									
Female										White										12-22-1882										85 YRS.										MONTHS DAYS HOURS MIN.																			
7a. BIRTHPLACE (State or foreign country)										7b. CITIZEN OF WHAT COUNTRY?										8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>										9. COUNTY OF DEATH										12b. KIND OF BUSINESS OR INDUSTRY																			
Ohio										U.S.A.																				Prince George Md.										Rept Store																			
10. CITY OR TOWN OF DEATH										11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)										12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)										12b. KIND OF BUSINESS OR INDUSTRY																													
Lanham										Magnolia Gardens N.H.										Ret Saleswoman																																							
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE										13b. COUNTY										13c. CITY OR TOWN										13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>										13e. STREET AND NUMBER																			
Maryland										Prince George										Landover Hills										YES										4210-72nd Ave.																			
14. FATHER'S NAME										15. MOTHER'S MAIDEN NAME										16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown (If yes give war or dates of service)										16b. SOCIAL SECURITY NO.										17. INFORMANT										Address									
John										Suedkamp										Mary										Koch																													
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4129 Rt. femoral thrombosis										DUE TO, OR AS A CONSEQUENCE OF (b) Atherosclerotic heart disease										DUE TO, OR AS A CONSEQUENCE OF (c)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH																													
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.																														2w																													
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 4200 Osteoarthritis. Rt. hemiplegia with aphasia																																																											
19a. DATE OF OPERATION										19b. CONDITION FOR WHICH OPERATION WAS PERFORMED										20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>										20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?																													
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)										21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19										21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)																																							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>										21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)										21f. LOCATION Street or R.F.D. No. City or Town County State																																							
22a. I certify that (I) (this hospital) attended the deceased from July 19, 1967, to July 14, 1968, that (I) (we) lost saw the deceased alive on July 11, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.																																																											
22b. SIGNATURE Harry Sacks, M.D.										DEGREE										ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>										22c. DATE SIGNED 7/14/68																													
22d. PHYSICIAN'S NAME (Type) Harry Sacks, M.D.																				22e. ADDRESS 3036 M Place, S.E. Wash. D.C.																																							
23a. BURIAL, CREMATION, REMOVAL (Specify)										23b. DATE 7/17/68										23c. NAME OF CEMETERY OR CREMATORY Ft. Lincoln										23d. LOCATION (City or Town) (County) (State) Colmar Manor P.G. Md.																													
24. FUNERAL DIRECTOR Francis Gasch's Sons Hyattsville, Md.										ADDRESS										25a. REC'D BY REGISTRAR JUL 17 1968										25b. REGISTRAR'S SIGNATURE Charles Judge																													

RECEIVED
JUL 10 1964
FBI - LOS ANGELES

TO: SAC, LOS ANGELES (44-1571)
FROM: SAC, SAN FRANCISCO (44-1111) (P)
SUBJECT: [Illegible]
[The body of the letter contains several paragraphs of text that are mostly illegible due to fading and bleed-through from the reverse side. Some words like "information", "advised", and "contact" are faintly visible.]

**FOR STATE
HEALTH DEPT.**

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

Item 21 film 403
8-5-68 mt DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or Print) Louis Simmons				20. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> Month 7 Day 26 Year 1968				2b. HOUR 10:06 a M		
3. SEX male		4. RACE Negro		5. DATE OF BIRTH 4-14-32		6. AGE (In years last birthday) 36 YRS		7. DATE PRONOUNCED DEAD Month 7 Day 26 Year 1968		
7a. BIRTHPLACE (State or foreign country) Va.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Prince George's Md.				
10. CITY OR TOWN OF DEATH Cheverly			11. NAME OF HOSPITAL OR INSTITUTION (if not in hospital give street address) Prince George's Hospital			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)			12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Md. COUNTY Prince George's			13b. CITY OR TOWN Baltimore			13c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 2129 North Street		
14. FATHER'S NAME First Johnnie Middle Moore Last Simmons				15. MOTHER'S MAIDEN NAME First Fannie Middle Mae Last Garrett						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No				16b. SOCIAL SECURITY NO. 227 36 8529		17. INFORMANT ADDRESS Suzanne Simmons 1805 N. Mount St.				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Intra-cerebral hemorrhage DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 17 days		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 1340										
19a. DATE OF OPERATION 7-11-68				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED Intra-cerebral hemorrhage				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY Month, Day, Year 11:00 p.m. 7-9 1968		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) fell off truck						
21d. INJURY OCCURRED WHILE AT WORK <input checked="" type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) 8800 blk Montpelier Dr.		21f. LOCATION Street or R.F.D. No. Bowie,		City or Town P.G.		State Md.		
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>										
ACTUAL SIGNATURE John Kehoe M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		
EXAMINER'S NAME (Type) John Kehoe M.D., Riverdale, Maryland				ADDRESS (Street, city, town, or county)		22b. DATE SIGNED 7-27-68				
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 7/30/68		23c. NAME OF CEMETERY OR CREMATORY Arbutus Mem. Pk.		23d. LOCATION (City or Town) Arbutus, Md.		(County) (State)		
24. FUNERAL DIRECTOR Kelson Fun'l Home				25a. REC'D BY REGISTRAR JUL 29 1968		25b. REGISTRAR'S SIGNATURE Charles J. J...				
V.R. Bailly 1348 N. Calhoun St.										

100-110-111-112-113-114-115-116-117-118-119-120-121-122-123-124-125-126-127-128-129-130-131-132-133-134-135-136-137-138-139-140-141-142-143-144-145-146-147-148-149-150-151-152-153-154-155-156-157-158-159-160-161-162-163-164-165-166-167-168-169-170-171-172-173-174-175-176-177-178-179-180-181-182-183-184-185-186-187-188-189-190-191-192-193-194-195-196-197-198-199-200-201-202-203-204-205-206-207-208-209-210-211-212-213-214-215-216-217-218-219-220-221-222-223-224-225-226-227-228-229-230-231-232-233-234-235-236-237-238-239-240-241-242-243-244-245-246-247-248-249-250-251-252-253-254-255-256-257-258-259-260-261-262-263-264-265-266-267-268-269-270-271-272-273-274-275-276-277-278-279-280-281-282-283-284-285-286-287-288-289-290-291-292-293-294-295-296-297-298-299-300-301-302-303-304-305-306-307-308-309-310-311-312-313-314-315-316-317-318-319-320-321-322-323-324-325-326-327-328-329-330-331-332-333-334-335-336-337-338-339-340-341-342-343-344-345-346-347-348-349-350-351-352-353-354-355-356-357-358-359-360-361-362-363-364-365-366-367-368-369-370-371-372-373-374-375-376-377-378-379-380-381-382-383-384-385-386-387-388-389-390-391-392-393-394-395-396-397-398-399-400-401-402-403-404-405-406-407-408-409-410-411-412-413-414-415-416-417-418-419-420-421-422-423-424-425-426-427-428-429-430-431-432-433-434-435-436-437-438-439-440-441-442-443-444-445-446-447-448-449-450-451-452-453-454-455-456-457-458-459-460-461-462-463-464-465-466-467-468-469-470-471-472-473-474-475-476-477-478-479-480-481-482-483-484-485-486-487-488-489-490-491-492-493-494-495-496-497-498-499-500-501-502-503-504-505-506-507-508-509-510-511-512-513-514-515-516-517-518-519-520-521-522-523-524-525-526-527-528-529-530-531-532-533-534-535-536-537-538-539-540-541-542-543-544-545-546-547-548-549-550-551-552-553-554-555-556-557-558-559-560-561-562-563-564-565-566-567-568-569-570-571-572-573-574-575-576-577-578-579-580-581-582-583-584-585-586-587-588-589-590-591-592-593-594-595-596-597-598-599-600-601-602-603-604-605-606-607-608-609-610-611-612-613-614-615-616-617-618-619-620-621-622-623-624-625-626-627-628-629-630-631-632-633-634-635-636-637-638-639-640-641-642-643-644-645-646-647-648-649-650-651-652-653-654-655-656-657-658-659-660-661-662-663-664-665-666-667-668-669-670-671-672-673-674-675-676-677-678-679-680-681-682-683-684-685-686-687-688-689-690-691-692-693-694-695-696-697-698-699-700-701-702-703-704-705-706-707-708-709-710-711-712-713-714-715-716-717-718-719-720-721-722-723-724-725-726-727-728-729-730-731-732-733-734-735-736-737-738-739-740-741-742-743-744-745-746-747-748-749-750-751-752-753-754-755-756-757-758-759-760-761-762-763-764-765-766-767-768-769-770-771-772-773-774-775-776-777-778-779-780-781-782-783-784-785-786-787-788-789-790-791-792-793-794-795-796-797-798-799-800-801-802-803-804-805-806-807-808-809-810-811-812-813-814-815-816-817-818-819-820-821-822-823-824-825-826-827-828-829-830-831-832-833-834-835-836-837-838-839-840-841-842-843-844-845-846-847-848-849-850-851-852-853-854-855-856-857-858-859-860-861-862-863-864-865-866-867-868-869-870-871-872-873-874-875-876-877-878-879-880-881-882-883-884-885-886-887-888-889-890-891-892-893-894-895-896-897-898-899-900-901-902-903-904-905-906-907-908-909-910-911-912-913-914-915-916-917-918-919-920-921-922-923-924-925-926-927-928-929-930-931-932-933-934-935-936-937-938-939-940-941-942-943-944-945-946-947-948-949-950-951-952-953-954-955-956-957-958-959-960-961-962-963-964-965-966-967-968-969-970-971-972-973-974-975-976-977-978-979-980-981-982-983-984-985-986-987-988-989-990-991-992-993-994-995-996-997-998-999-1000-1001-1002-1003-1004-1005-1006-1007-1008-1009-1010-1011-1012-1013-1014-1015-1016-1017-1018-1019-1020-1021-1022-1023-1024-1025-1026-1027-1028-1029-1030-1031-1032-1033-1034-1035-1036-1037-1038-1039-1040-1041-1042-1043-1044-1045-1046-1047-1048-1049-1050-1051-1052-1053-1054-1055-1056-1057-1058-1059-1060-1061-1062-1063-1064-1065-1066-1067-1068-1069-1070-1071-1072-1073-1074-1075-1076-1077-1078-1079-1080-1081-1082-1083-1084-1085-1086-1087-1088-1089-1090-1091-1092-1093-1094-1095-1096-1097-1098-1099-1100-1101-1102-1103-1104-1105-

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

Item 22a Film 404 9-24-68 ams DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										10548		
MEDICAL EXAMINER'S CERTIFICATE OF DEATH 10539												
1. DECEASED-NAME (Type or Print) First Middle Last Marsha Louise Skeens						2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> Month Day Year 7 30-68 197			2b. HOUR 20pm			
3. SEX Female		4. RACE White		5. DATE OF BIRTH 2-12-1944		6. AGE (In years last birthday) 24 YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN		2c. DATE PRONOUNCED DEAD Month Day Year 7 30 68 197		
7a. BIRTHPLACE (State or foreign country) Washington D C		7b. CITIZEN OF WHAT COUNTRY? U S A		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Prince George's Md.						
10. CITY OR TOWN OF DEATH Riverdale				11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Leland Memorial Hospital				12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) housewife			12b. KIND OF BUSINESS OR INDUSTRY home	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland				13b. COUNTY Prince George's		13c. CITY OR TOWN Landover		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 5119 Flintridge Drive		
14. FATHER'S NAME First Middle Last Salvatore Turrisi				15. MOTHER'S MAIDEN NAME First Middle Last Esther Parsons								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no				16b. SOCIAL SECURITY NO. (If yes give war or dates of service)		17. INFORMANT ADDRESS James T Skeens Landover, Md.						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Gun shot wound of abdomen</u> 985X DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 919.0												
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				
21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY Month, Day, Year 6:37pm 7-30- 19 68		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)								
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) 5309 Riverdale Road, Riverdale, Prince George County, Maryland		21f. LOCATION Street or R.F.D. No. City or Town County State								
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input checked="" type="checkbox"/>												
ACTUAL SIGNATURE EXAMINER'S NAME (Type) John Kehoe MD		RIVERDALE, Maryland		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		22b. DATE SIGNED 7-31-68						
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE Aug 3, 1968		23c. NAME OF CEMETERY OR CREMATORY Ft Lincoln Cemetery		23d. LOCATION (City or Town) (County) (State) Colmar Manor Pro Geo Md.						
24. FUNERAL DIRECTOR F. Gasch's Sons				ADDRESS Hyattsville, Md.		25a. RECD BY REGISTRAR DATE AUG 5 1968		25b. REGISTRAR'S SIGNATURE Charles Judge				

10548

ATLANTA EXAMINING CERTIFICATE OF DEATH

10548

DATE OF DEATH: 10-10-1918
TIME OF DEATH: 10:30 AM
PLACE OF DEATH: 10548

DECEASED'S NAME: 10548
AGE: 10548
SEX: 10548

DECEASED'S RESIDENCE: 10548
DECEASED'S OCCUPATION: 10548

DECEASED'S CAUSE OF DEATH: 10548
DECEASED'S MANNER OF DEATH: 10548

DECEASED'S SIGNATURE: 10548
DECEASED'S ADDRESS: 10548

DECEASED'S BIRTH DATE: 10548
DECEASED'S BIRTH PLACE: 10548

DECEASED'S MARRIAGE DATE: 10548
DECEASED'S MARRIAGE PLACE: 10548

DECEASED'S EDUCATION: 10548
DECEASED'S RELIGION: 10548

DECEASED'S SERVICE: 10548
DECEASED'S GRADE: 10548

DECEASED'S COMMENTS: 10548
DECEASED'S SIGNATURE: 10548

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or print) -			First Clifton	Middle R.	Last Smith	2a. DATE OF DEATH Month Day Year 7 31 68			2b. HOUR 6:15 PM		
3. SEX Male		4. RACE White		5. DATE OF BIRTH 5-4-03		6. AGE (In years last birthday) 65 YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (State or foreign country) Maryland		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Prince George Md.					
10. CITY OR TOWN OF DEATH Riverdale			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Eugene Leland Memorial			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Retired			12b. KIND OF BUSINESS OR INDUSTRY W S S C		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland			13b. COUNTY Prince George		13c. CITY OR TOWN Hyattsville		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 5306 Kenilworth Ave.		
14. FATHER'S NAME First Middle Last Edward Smith			15. MOTHER'S MAIDEN NAME First Middle Last Goldie McCauley								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown)			16b. SOCIAL SECURITY NO. (If yes give war or dates of service)		17. INFORMANT Address Spouse and Medical Records						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Ruptured abdominal aortic aneurysm</u> <u>441.2</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>ONE DAY</u>		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) <u>451X</u>											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <u>YES</u>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1B.)							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State							
22a. I certify that (I) (this hospital) attended the deceased from <u>31 JULY</u> , 19 <u>68</u> , to <u>31 JULY</u> , 19 <u>68</u> , that (I) (we) last saw the deceased alive on <u>31 JULY</u> 19 <u>68</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. <u>DR. KENOE NOTIFIED</u>											
22b. SIGNATURE <u>C. J. Houmann</u>				DEGREE ATTENDING PHYS.		<input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS.		22c. DATE SIGNED 8-1-68			
22d. PHYSICIAN'S NAME (Type) C. J. Houmann, M.D.				22e. ADDRESS 4408 Queensbury Rd., Riverdale, Md.							
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE Aug 3, 1968		23c. NAME OF CEMETERY OR CREMATORY Ft Lincoln Cemetery		23d. LOCATION (City or Town) (County) (State) Colmar Manor Pro Geo Md.					
24. FUNERAL DIRECTOR F. Gasch's Sons				ADDRESS Hyattsville Md.		25a. REC'D BY REGISTRAR DATE AUG 5 1968		25b. REGISTRAR'S SIGNATURE <u>J. Charles Judge</u>			

340

TESTIMONY OF DEATH

1. Name of deceased: _____
2. Age: _____
3. Sex: _____
4. Date of death: _____
5. Place of death: _____
6. Cause of death: _____
7. Signature of witness: _____
8. Signature of doctor: _____
9. Signature of registrar: _____
10. Signature of informant: _____
11. Signature of medical officer: _____
12. Signature of health officer: _____
13. Signature of coroner: _____
14. Signature of jury: _____
15. Signature of judge: _____
16. Signature of clerk: _____
17. Signature of sheriff: _____
18. Signature of constable: _____
19. Signature of justice: _____
20. Signature of magistrate: _____
21. Signature of mayor: _____
22. Signature of council: _____
23. Signature of committee: _____
24. Signature of board: _____
25. Signature of commission: _____
26. Signature of department: _____
27. Signature of ministry: _____
28. Signature of government: _____
29. Signature of parliament: _____
30. Signature of congress: _____
31. Signature of senate: _____
32. Signature of house: _____
33. Signature of court: _____
34. Signature of tribunal: _____
35. Signature of authority: _____
36. Signature of power: _____
37. Signature of jurisdiction: _____
38. Signature of competence: _____
39. Signature of capacity: _____
40. Signature of ability: _____
41. Signature of skill: _____
42. Signature of knowledge: _____
43. Signature of wisdom: _____
44. Signature of understanding: _____
45. Signature of intelligence: _____
46. Signature of reason: _____
47. Signature of logic: _____
48. Signature of science: _____
49. Signature of art: _____
50. Signature of craft: _____
51. Signature of trade: _____
52. Signature of profession: _____
53. Signature of occupation: _____
54. Signature of vocation: _____
55. Signature of career: _____
56. Signature of path: _____
57. Signature of journey: _____
58. Signature of voyage: _____
59. Signature of expedition: _____
60. Signature of quest: _____
61. Signature of search: _____
62. Signature of inquiry: _____
63. Signature of investigation: _____
64. Signature of research: _____
65. Signature of study: _____
66. Signature of learning: _____
67. Signature of education: _____
68. Signature of training: _____
69. Signature of instruction: _____
70. Signature of teaching: _____
71. Signature of tutoring: _____
72. Signature of mentoring: _____
73. Signature of coaching: _____
74. Signature of guiding: _____
75. Signature of leading: _____
76. Signature of directing: _____
77. Signature of managing: _____
78. Signature of administering: _____
79. Signature of governing: _____
80. Signature of ruling: _____
81. Signature of controlling: _____
82. Signature of commanding: _____
83. Signature of ordering: _____
84. Signature of arranging: _____
85. Signature of organizing: _____
86. Signature of planning: _____
87. Signature of designing: _____
88. Signature of creating: _____
89. Signature of inventing: _____
90. Signature of developing: _____
91. Signature of growing: _____
92. Signature of maturing: _____
93. Signature of ripening: _____
94. Signature of blossoming: _____
95. Signature of fruiting: _____
96. Signature of bearing: _____
97. Signature of producing: _____
98. Signature of generating: _____
99. Signature of creating: _____
100. Signature of making: _____



1. Name of deceased: _____
2. Age: _____
3. Sex: _____
4. Date of death: _____
5. Place of death: _____
6. Cause of death: _____
7. Signature of witness: _____
8. Signature of doctor: _____
9. Signature of registrar: _____
10. Signature of informant: _____
11. Signature of medical officer: _____
12. Signature of health officer: _____
13. Signature of coroner: _____
14. Signature of jury: _____
15. Signature of judge: _____
16. Signature of clerk: _____
17. Signature of sheriff: _____
18. Signature of constable: _____
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66. Signature of learning: _____
67. Signature of education: _____
68. Signature of training: _____
69. Signature of instruction: _____
70. Signature of teaching: _____
71. Signature of tutoring: _____
72. Signature of mentoring: _____
73. Signature of coaching: _____
74. Signature of guiding: _____
75. Signature of leading: _____
76. Signature of directing: _____
77. Signature of managing: _____
78. Signature of administering: _____
79. Signature of governing: _____
80. Signature of ruling: _____
81. Signature of controlling: _____
82. Signature of commanding: _____
83. Signature of ordering: _____
84. Signature of arranging: _____
85. Signature of organizing: _____
86. Signature of planning: _____
87. Signature of designing: _____
88. Signature of creating: _____
89. Signature of inventing: _____
90. Signature of developing: _____
91. Signature of growing: _____
92. Signature of maturing: _____
93. Signature of ripening: _____
94. Signature of blossoming: _____
95. Signature of fruiting: _____
96. Signature of bearing: _____
97. Signature of producing: _____
98. Signature of generating: _____
99. Signature of creating: _____
100. Signature of making: _____

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3, Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

10541

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

10550

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

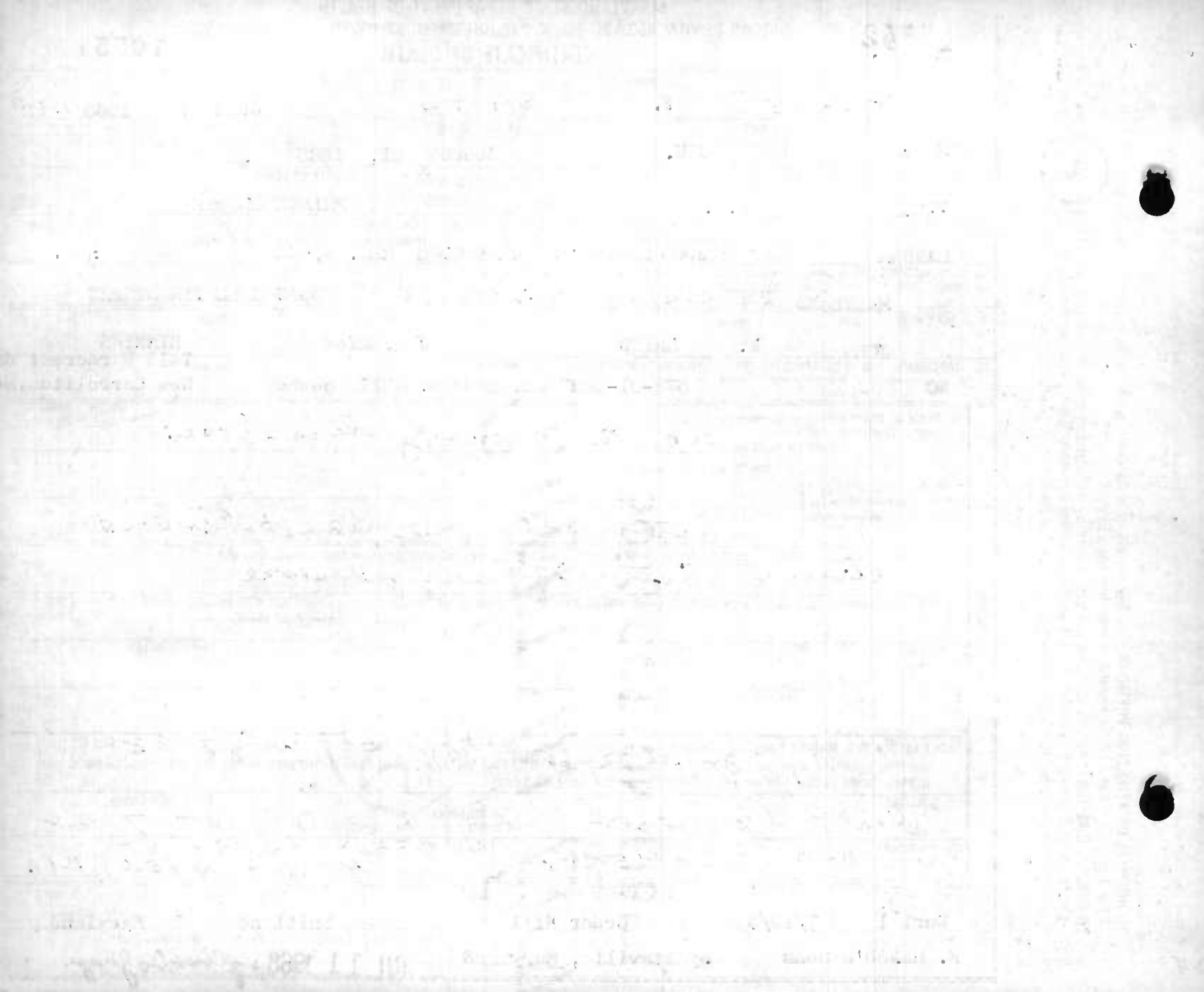
1. DECEASED-NAME (Type or Print) First Middle Last FRANK VINCENT SMITH				2a. DATE KNOWN OF ESTI-DEATH MATED <input checked="" type="checkbox"/> Month Day Year July 6 1968				2b. HOUR 1:05 PM	
3. SEX M	4. RACE W	5. DATE OF BIRTH Sept 23 1936	6. AGE (In years last birthday) 32 YRS	IF UNDER 1 YEAR MONTHS DAYS 0 0		IF UNDER 24 HRS HOURS MIN 0 0		2c. DATE PRONOUNCED DEAD Month Day Year July 6 1968	
7a. BIRTHPLACE (State or foreign country) Maryland		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Prince Georges			
10. CITY OR TOWN OF DEATH Chesley		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Prince Georges		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Carpenter Construction				12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (Where deceased lived, if institution residence before admission) STATE MD		13b. COUNTY Prince Georges		13c. CITY OR TOWN Fort Detrick		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 6800 Fort Detrick	
14. FATHER'S NAME First Middle Last Joseph P Smith				15. MOTHER'S MAIDEN NAME First Middle Last Edna M Alvey					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)				16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS CAROL A. Smith Same as #13			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Toxemia + Shock. DUE TO, OR AS A CONSEQUENCE OF DUE TO, OR AS A CONSEQUENCE OF DUE TO, OR AS A CONSEQUENCE OF 5770 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 5870									
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No.		City or Town		County State	
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> CHIEF MEDICAL EXAMINER <input type="checkbox"/> 7-6-68 ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> 22b. DATE SIGNED DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> 5315 Annapolis ADDRESS (Street, city, town, or county) Beltsville, Md.									
ACTUAL SIGNATURE Dayton O Watkins		EXAMINER'S NAME (Type) DAYTON O. WATKINS							
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE July 9, 68		23c. NAME OF CEMETERY OR CREMATORY Trinity Memorial Garden - Waldorf, Maryland.		23d. LOCATION (City or Town) (County) (State) Waldorf, Maryland.			
24. FUNERAL DIRECTOR Simmons Bros.				ADDRESS Wash. D.C.		25a. REC'D BY REGISTRAR JUL - 8 1968		25b. REGISTRAR'S SIGNATURE Charles Judge	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers (pages 1 and 2) should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
30M REV. 1/68

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
CERTIFICATE OF DEATH									
1. DECEASED-NAME (Type or print) GRACE			First V. Middle SMITH Last			2a. DATE OF DEATH Month JULY Day 7 Year 1968		2b. HOUR 10:55 PM	
3. SEX FEMALE		4. RACE CAU.		5. DATE OF BIRTH AUGUST 21, 1885		6. AGE (In years last birthday) 82 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN. 	
7a. BIRTHPLACE (State or foreign country) VIRGINIA		7b. CITIZEN OF WHAT COUNTRY? U.S.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH PRINCE GEORGE Md.			
10. CITY OR TOWN OF DEATH LANHAM		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) MAGNOLIA GARDENS REST HOME		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) REG. NURSE		12b. KIND OF BUSINESS OR INDUSTRY MED.			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE MARYLAND		13b. CITY OR TOWN PRINCE GEORGE		13c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 3603 GALLATIN STREET			
14. FATHER'S NAME First JOHN Middle W. Last SMITH			15. MOTHER'S MAIDEN NAME First JAQUELINE Middle HINKINS Last			16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, NO (If yes give war or dates of service)			
16b. SOCIAL SECURITY NO. 578-01-5627			17. INFORMANT RICHARD M. SMITH Nephew			Address 7419 Farmcrest dr New Carrollton, Md			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: 4109 IMMEDIATE CAUSE (a) acute coronary thrombosis DUE TO, OR AS A CONSEQUENCE OF (b) DUE TO, OR AS A CONSEQUENCE OF (c) atherosclerotic heart disease								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 4201 chronic obstructive lung disease									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from July 1, 1968 to July 7, 1968 that (I) (we) lost saw the deceased alive on June 22, 1968 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE Don B. Cameron				DEGREE 		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED 7-7-68	
22d. PHYSICIAN'S NAME (Type) DON B. CAMERON				22e. ADDRESS 3503 PERRY ST. MT. RAINIER, MD					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 7/10/68		23c. NAME OF CEMETERY OR CREMATORY Cedar Hill		23d. LOCATION (City or Town) (County) (State) Suitland Maryland			
24. FUNERAL DIRECTOR F. Gasch's Sons				ADDRESS Hyattsville, Maryland		25a. REC'D BY REGISTRAR JUL 11 1968		25b. REGISTRAR'S SIGNATURE Charles Judge	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
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DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201													
CERTIFICATE OF DEATH													
1. DECEASED-NAME (Type or print)			First MARIAN Marian			Middle M.		Last Smith		2a. DATE OF DEATH Month 7 Day 5 Year 68		2b. HOUR 330P M	
3. SEX Female		4. RACE White		5. DATE OF BIRTH 7-9-97			6. AGE (In years lost birthday) 70 YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.		
7a. BIRTHPLACE (State or foreign country) Harrisburg, Va.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH Prince Georges Md.						
10. CITY OR TOWN OF DEATH Clinton			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Clinton Community Hosp.			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Housewife			12b. KIND OF BUSINESS OR INDUSTRY				
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE D.C.			13b. COUNTY Washington		13c. CITY OR TOWN Washington		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 5510 4th Street N. W.				
14. FATHER'S NAME First George Middle E. Last Shreve			15. MOTHER'S MAIDEN NAME First Sullivan Middle Last Sullivan										
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown unknown			16b. SOCIAL SECURITY NO.		17. INFORMANT Augustus G. Smith, Jr. 5510 4th St N.W. Wash								
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial Infarction 4109 DUE TO, OR AS A CONSEQUENCE OF Generalized Atherosclerosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: 4201 (b) (c) APPROXIMATE INTERVAL C. BETWEEN ONSET AND DEATH 12 Days CNK													
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(g) Congestive Heart Failure, Deep vein Thrombosis													
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?						
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)								
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State								
22a. I certify that (I) (this hospital) attended the deceased from 6/24/68 19, to 7/5/68 19, that (I) (we) last saw the deceased alive on 7/5/68 19, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.													
22b. SIGNATURE Robert W. Merkle, M.D.					DEGREE M.D.		ATTENDING PHYS. <input checked="" type="checkbox"/>		MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED 7/5/68		
22d. PHYSICIAN'S NAME (Type) Robert W. Merkle, M.D.					22e. ADDRESS 116 McKendree Rd., Brandywine, Md.								
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 7-9-1968		23c. NAME OF CEMETERY OR CREMATORY Resurrection Cemetery			23d. LOCATION (City or Town) (County) (State) Clinton P G Maryland						
24. FUNERAL DIRECTOR Robert E. Wilhelm Funeral Home 4308 Suitland Road Suitland Maryland						25a. REC'D BY REGISTRAR JUL 11 1968		25b. REGISTRAR'S SIGNATURE J. Charles Judge					

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
CERTIFICATE OF DEATH									
1. DECEASED-NAME (Type or print)			First Middle Last			2a. DATE OF DEATH Month Day Year			2b. HOUR
Mary Agnes Sprouse						July 13 1968			M
3. SEX	4. RACE		5. DATE OF BIRTH			6. AGE (In years last birthday)		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN	
Female	White					76 YRS.			
7a. BIRTHPLACE (State or foreign country)	7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH				
U.S.A.	U.S.A.				Prince George's County Md.				
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)			12b. KIND OF BUSINESS OR INDUSTRY
Forestville			Regent Nursing Home			Retired			
13a. USUAL RESIDENCE (Where deceased lived, if institution-Residence before admission) STATE			13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER
Maryland			Montgomery		Hyattsville		YES <input type="checkbox"/> NO <input type="checkbox"/>		7402 Jefferson St.
14. FATHER'S NAME First Middle Last			15. MOTHER'S MAIDEN NAME First Middle Last						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown			16b. SOCIAL SECURITY NO.		17. INFORMANT Address				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)									
PART 1. DEATH WAS CAUSED BY:									
IMMEDIATE CAUSE (a) <u>Respiratory arrest</u> Summed									
DUE TO, OR AS A CONSEQUENCE OF									
(b) <u>Metastatic carcinoma</u>									
DUE TO, OR AS A CONSEQUENCE OF									
(c) <u>Advanced Ca Breast 1 yr</u>									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH, BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
170x <u>Advanced Anemia due to Chronic Pyelonephritis</u>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY Hour A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No.		City or Town		County State	
22a. I certify that (I) (this hospital) attended the deceased from <u>7/25/67</u> , to <u>7/13/68</u> , that (I) (we) last saw the deceased alive on <u>7/12/68</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE		22c. DATE SIGNED							
<u>Kelvin L. Minchin M.D.</u>		<u>7/13/68</u>							
22d. PHYSICIAN'S NAME (Type)		22e. ADDRESS							
<u>KELVIN L. MINCHIN</u>		<u>6400 MARLBORO PIKE SE</u>							
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)			
		<u>7-17-68</u>		<u>CONGRESSIONAL</u>		<u>WASH. D.C.</u>			
24. FUNERAL DIRECTOR		ADDRESS		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE			
<u>W W Chambers</u>		<u>1400 Chapin St NW</u>		<u>JUL 17 1968</u>		<u>[Signature]</u>			

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FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

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Items 18&22a Film 404 Maryland State Department of Health
9-25-68 ams DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10545 10554

1. DECEASED-NAME (Type or Print)			First Robert			Middle C			Last Stanwood			20. DATE KNOWN OF ESTI- DEATH MATED <input checked="" type="checkbox"/> 7-27-68 19 ? M			2b. HOUR								
3. SEX Male		4. RACE White		5. DATE OF BIRTH 12-27-1921		6. AGE (In years last birthday) 46 YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN		2c. DATE PRONOUNCED DEAD Month 7 Day 30 Year 68 1977:03pm M			2d. HOUR								
7a. BIRTHPLACE (State or foreign country) Illinois				7b. CITIZEN OF WHAT COUNTRY? USA				8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				9. COUNTY OF DEATH Prince George's Md.											
10. CITY OR TOWN OF DEATH Cheverly				11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Prince George Hospital				12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Manager				12b. KIND OF BUSINESS OR INDUSTRY Retail Store											
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland								13b. COUNTY Prince George's				13c. CITY OR TOWN Oxon Hill		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 2900 St. Clair Drive, #422							
14. FATHER'S NAME First Robert C. Middle Stanwood Last						15. MOTHER'S MAIDEN NAME First Bea Middle Roth Last						16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) YES <input checked="" type="checkbox"/> 1942-46 (If yes give war or dates of service)						16b. SOCIAL SECURITY NO. 490101015		17. INFORMANT (Brother) 3122 ADDRESS Panorama Road Hubert C. Stanwood, Riverside, California			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Heart failure 4120 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Hypertensive cardiovascular disease DUE TO, OR AS A CONSEQUENCE OF (c)														APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Minutes Unknown									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 443X																							
19a. DATE OF OPERATION						19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>											
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 19				21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1B.)															
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)				21f. LOCATION Street or R.F.D. No.				City or Town				County				State			
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>																							
ACTUAL SIGNATURE John Kehoe MD						M.D.						CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> ADDRESS (Street, city, town, or county)						22b. DATE SIGNED 7-31-68					
23a. BURIAL, CREMATION, REMOVAL (Specify) Cremation				23b. DATE 8-2-68				23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery				23d. LOCATION (City or Town) (County) (State) Suitland, Maryland											
24. FUNERAL DIRECTOR Wilhelm Funeral Home 4308 Suitland Rd. SE, Suitland, Maryland										25a. REC'D BY REGISTRAR DATE AUG 8 1968				25b. REGISTRAR'S SIGNATURE J. Charles Judge									

STATE OF
NEW YORK

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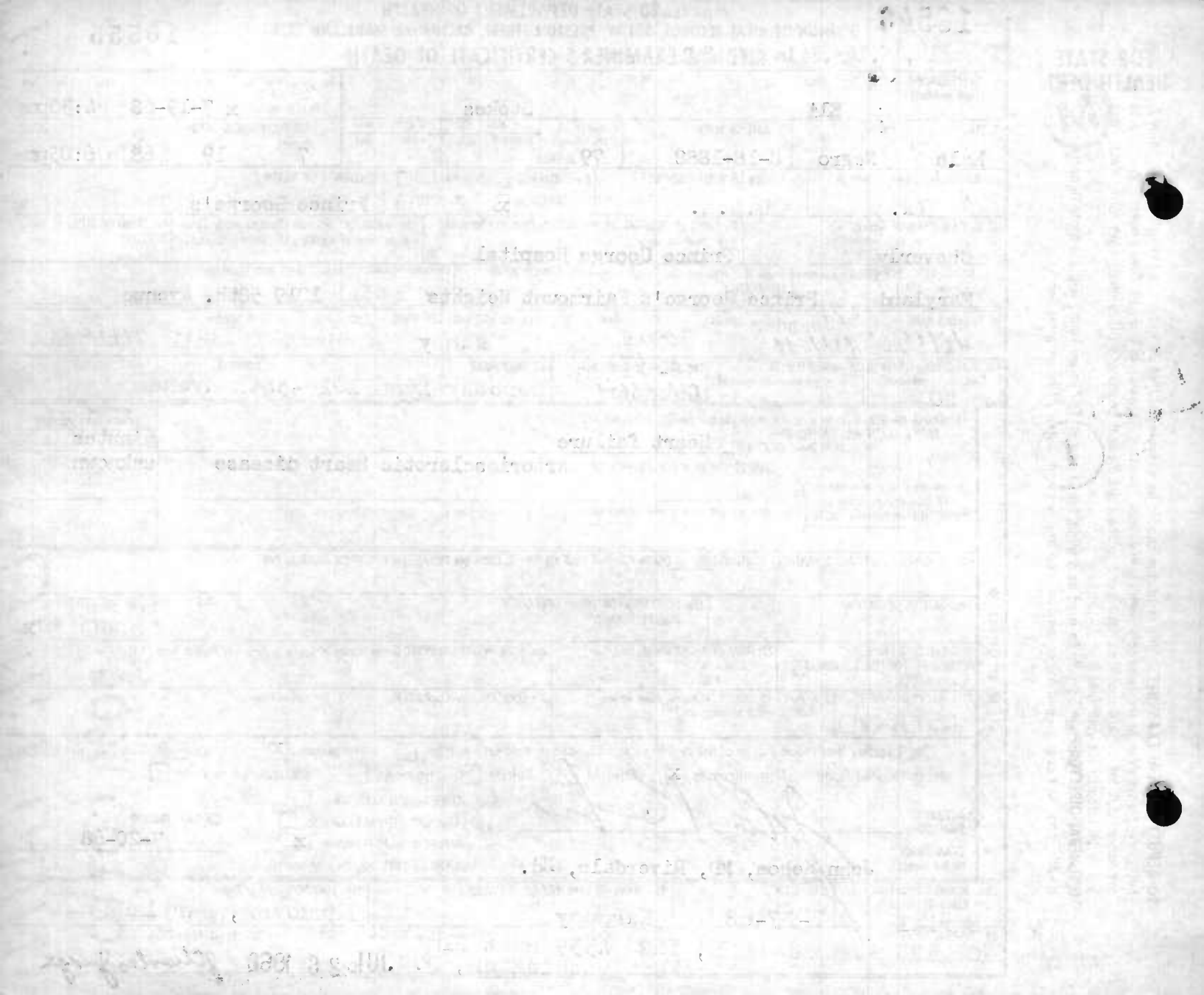
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FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

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10546 DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										10555		
Item #14, 15, 16b, Film C MEDICAL EXAMINER'S CERTIFICATE OF DEATH												
1. DECEASED-NAME (Type or Print) Eli Stokes						2a. DATE KNOWN OF DEATH MATED <input checked="" type="checkbox"/> 7-19-68 194:30pm				2b. HOUR		
3. SEX Male		4. RACE Negro		5. DATE OF BIRTH 8-18-1888		6. AGE (In years last birthday) 79 YRS.		IF UNDER 1 YEAR MONTHS _____ DAYS _____		IF UNDER 24 HRS. HOURS _____ MIN _____		
7a. BIRTHPLACE (State or foreign country) Va.			7b. CITIZEN OF WHAT COUNTRY? U.S.A.			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH Prince George's Md.			
10. CITY OR TOWN OF DEATH Cheverly				11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Prince George Hospital				12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)			12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland				13b. COUNTY Prince George's				13c. CITY OR TOWN Fairmount Heights YES <input type="checkbox"/> NO <input type="checkbox"/>		13d. INSIDE CITY LIMITS? YES		
13e. STREET AND NUMBER 1019 58th. Avenue				14. FATHER'S NAME First Spencer Middle William Last Stokes				15. MOTHER'S MAIDEN NAME First Nancy Middle Ginny Last Hall				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO				16b. SOCIAL SECURITY NO. 428-8-8783				17. INFORMANT ADDRESS Dorothy Lynn 1019-58th Avenue				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Heart failure 4129 DUE TO, OR AS A CONSEQUENCE OF Arteriosclerotic heart disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF _____ (c) _____										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH minutes unknown		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 4800												
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY Month, Day, Year HOUR A.M. _____ P.M. 19				21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)				
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)				21f. LOCATION Street or R.F.D. No. _____ City or Town _____ County _____ State _____				
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>												
ACTUAL SIGNATURE John Kehoe M.D.						CHIEF MEDICAL EXAMINER <input type="checkbox"/>			22b. DATE SIGNED 7-20-68			
EXAMINER'S NAME (Type) John Kehoe, MD, Riverdale, Md.						ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
ADDRESS (Street, city, town, or county)						ADDRESS (Street, city, town, or county)						
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial				23b. DATE 7-27-68		23c. NAME OF CEMETERY OR CREMATORY Harmony			23d. LOCATION (City or Town) (County) (State) Landover, Maryland			
24. FUNERAL DIRECTOR ROLLINS FUNERAL HOME, INC ADDRESS 4339 Hunt Pl Washington,						25a. REC'D BY REGISTRAR DATE JUL 26 1968			25b. REGISTRAR'S SIGNATURE Charles Judge			



TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or print) Isaac		First		Middle		Last		2a. DATE OF DEATH Month July Day 22 Year 1968				2b. HOUR 8:20A M	
3. SEX Male		4. RACE White		5. DATE OF BIRTH 12/14/78				6. AGE (In years last birthday) 89 YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (State or foreign country) Russian		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Prince George's Md.							
10. CITY OR TOWN OF DEATH Cheverly		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Prince Geo. Gen. Hosp.				12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Super. Engineer				12b. KIND OF BUSINESS OR INDUSTRY			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland		13b. COUNTY Prince George's		13c. CITY OR TOWN Silver Spr.		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER 921 Northwest Dr.					
14. FATHER'S NAME First Middle Last		15. MOTHER'S MAIDEN NAME First Middle Last											
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown NO		16b. SOCIAL SECURITY NO. 218-32-9696		17. INFORMANT Address M. Leon Strauss 7905 Roston Ave									
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral aneurysm DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Acute myocardial infarction DUE TO, OR AS A CONSEQUENCE OF (c) Cerebral aneurysm APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 hr. ?/19/68 ?													
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a) 4201													
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)									
21d. INJURY OCCURRED While <input type="checkbox"/> Nat while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State									
22a. I certify that (I) Dr. Bernard J. Walsh attended the deceased from 7/19/68 to July 22, 1968 , that (I) (we) last saw the deceased alive on 7/22/68 , and that in (my) last opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.													
22b. SIGNATURE Bernard J. Walsh M.D.		DEGREE		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED 7/22/68							
22d. PHYSICIAN'S NAME (Type) BERNARD J. WALSH, MD		22e. ADDRESS 1800 Eye St. N.W. DC											
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 7/23/1968		23c. NAME OF CEMETERY OR CREMATORY Sharon Heights				23d. LOCATION (City or Town) (County) (State) Balto Md					
24. FUNERAL DIRECTOR Sylvan S. Lerner & Son, INC		25a. REC'D BY REGISTRAR JUL 24 1968											
		25b. REGISTRAR'S SIGNATURE f Charles Judge											

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FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
MEDICAL EXAMINER'S CERTIFICATE OF DEATH									
1. DECEASED-NAME (Type or Print)			First Middle Last			2. DATE KNOWN OF DEATH			
Louis			L.			Strickler			Month Day Year
3. SEX			4. RACE		5. DATE OF BIRTH		6. AGE (in years last birthday)		2b. HOUR p M
male			white		10-1-28		39 YRS.		10:00 p M
7a. BIRTHPLACE (State or foreign country)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH	
Virginia			U.S.A.					Prince George's Md	
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY	
Riverdale			Leland Memorial Hospital			Carpenter		Building	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE			13b. COUNTY			13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
Md.			P.G.			Riverdale		5810 Cleveland Avenue	
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME						
First Middle Last			First Middle Last						
EDWARD S. STRICKLER			MARGARET GOOD						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16b. SOCIAL SECURITY NO.			17. INFORMANT ADDRESS			
No			None			Unknown			
						Connie M. Strickler, Ave., Riverdale, Md			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)									
PART 1. DEATH WAS CAUSED BY:									
IMMEDIATE CAUSE (a) <u>Intracerebral and Subarachnoid Hemorrhage</u>									
DUE TO, OR AS A CONSEQUENCE OF									
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.									
(b) <u>431.9</u>									
DUE TO, OR AS A CONSEQUENCE OF									
(c)									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)									
<u>331.9</u>									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY Month, Day, Year		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)				
			HOUR A.M. P.M.		19				
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)			21f. LOCATION Street or R.F.D. No. City or Town County State				
22a. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>									
22a. I certify that I took charge of the remains described above, held on			Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion						
Actual Signature			M.D.						
EXAMINER'S NAME (Type)			John Kehoe M.D., Riverdale, Maryland						
23a. BURIAL, CREMATION, REMOVAL (Specify)			23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)		
Burial			July 13, 1968		Fort Lincoln Cemetery		Bladensburg, Maryland		
24. FUNERAL DIRECTOR			ADDRESS				25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE
W. W. CHAMBERS CO.			Riverdale, Md.				JUL 15 1968		Charles Judge

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TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
30M REV. 3/68

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
10549									
10558									
CERTIFICATE OF DEATH									
1. DECEASED-NAME (Type or print) George			First C. Middle Sullivan Last			2a. DATE OF DEATH Month 7 Day 28 Year 68		2b. HOUR 1:45 ^a _M	
3. SEX Male		4. RACE White		5. DATE OF BIRTH 10/11/01		6. AGE (In years lost birthday) 66 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (State or foreign country) D.C.		7b. CITIZEN OF WHAT COUNTRY? U.S.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Prince Georges _{Md.}			
10. CITY OR TOWN OF DEATH Riverdale		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Leland Memorial Hospital		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Retired		12b. KIND OF BUSINESS OR INDUSTRY farmer			
13a. USUAL RESIDENCE (Where deceased admission) STATE Md.		13b. COUNTY Prince Georges		13c. CITY OR TOWN Beltsville		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER P.O. Box 61	
14. FATHER'S NAME First Robert Middle Sullivan Last			15. MOTHER'S MAIDEN NAME First Mamie Middle R Last iseley						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) no (If yes give war or dates of service)		16b. SOCIAL SECURITY NO. 213 32 4549		17. INFORMANT Edna Sullivan		Address Beltsville, Md.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Renal Failure - Azotemia 571.9 DUE TO, OR AS A CONSEQUENCE OF (b) Hepatic Failure DUE TO, OR AS A CONSEQUENCE OF (c) Cirrhosis of Liver Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) 5810								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 mo 1 yr 3 yrs.	
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE, BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from 7/4/68 , 19 68 , to 7/28 , 19 68 , that (I) (we) last saw the deceased alive on 7-27-68 , and that in (my) (our) opinion death occurred on the date and hour and from the causes noted above (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE U.L. Etienne		22c. DATE SIGNED 7-28-68		22d. PHYSICIAN'S NAME (Type) U.L. ETIENNE		22e. ADDRESS College Park, Md			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE July 31, 1968		23c. NAME OF CEMETERY OR CREMATORY George Washington		23d. LOCATION (City or Town) (County) (State) Hyattsville Pro Geo Md			
24. FUNERAL DIRECTOR ADDRESS F. Gasch's Sons Hyattsville Md				25a. REC'D BY REGISTRAR DATE AUG 1 1968		25b. REGISTRAR'S SIGNATURE Charles Judge			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
30M REV. 1/68

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
CERTIFICATE OF DEATH									
1. DECEASED-NAME (Type or print)			First	Middle	Last	2a. DATE OF DEATH		2b. HOUR	
THOMAS I. SWANN						7 th Month 19 th Day 1968		11 ⁵⁵ M	
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
M		W		3/16/1887		81 YRS.			
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH			
MD.		U.S.A.				PRINCE GEORGES Md.			
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b. KIND OF BUSINESS OR INDUSTRY	
CLINTON			CLINTON COMMUNITY HOSP			RR Conductor - Railroad			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE			13b. COUNTY			13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
MD.			PR. GEO. BRANDYWINE			RT 2 BOX 280			
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME						
First Middle Last			First Middle Last						
UNKNOWN			UNKNOWN						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) (If yes give war or dates of service)			16b. SOCIAL SECURITY NO.			17. INFORMANT			
NO			717-07-8109			EDITH R. SWANN BRANDYWINE, MD			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4129 RESPIRATORY ARREST DUE TO, OR AS A CONSEQUENCE OF (b) TERMINAL BRONCHOPNEUMONIA DUE TO, OR AS A CONSEQUENCE OF (c) Cerebrovascular accident - Arteriosclerotic C.V. Disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 5 MIN. 8 DAYS 11 DAYS	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 4221 NONE									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
NONE		NONE		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> TO CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
NONE		NONE		NONE					
21d. INJURY OCCURRED While <input checked="" type="checkbox"/> at work <input type="checkbox"/> Not while at work		21e. PLACE OF INJURY (At home, farm, street, factory, office, building, etc.)		21f. LOCATION		Street or R.F.D. No		City or Town County State	
NONE		NONE		NONE		NONE			
22a. I certify that (I) (this hospital) attended the deceased from MARCH, 1966, to PRESENT, that (I) (we) last saw the deceased alive on JULY 19, 1968 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE						22c. DATE SIGNED			
Arthur Shaver Jr. MD						7/20/68			
22d. PHYSICIAN'S NAME (Type)						22e. ADDRESS			
ARTHUR SHAVER JR. MD.						8808 BRANCH AVE. - CLINTON, MD.			
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)			
Burial		7-23-1968		Cedar Hill		Baltimore P. GEO. MD			
24. FUNERAL DIRECTOR		ADDRESS		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE			
HUNT FUNERAL HOME		WADSWORTH, MD		DATE JUL 24 1968		J. Charles J. J.			

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FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR 415ME (5)
10M REV. 1/68

10552

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10560

1. DECEASED-NAME (Type or Print)			First Middle Last			2a. DATE KNOWN OF ESTI- DEATH MATED <input checked="" type="checkbox"/> <input type="checkbox"/> Month Day Year				2b. HOUR PM				
Clarence Theodore Sword							7-10-68				PM			
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (In years last birthday)	IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN		2c. DATE PRONOUNCED DEAD Month Day Year				2d. HOUR PM		
Male	White	8-7-1900	67 YRS.					7th 19 68				10:30pm		
7a. BIRTHPLACE (State or foreign)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH						Md.		
Washington D. C.		U. S. A.				Prince George's								
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)			12b. USUAL BUSINESS OR INDUSTRY					
Brentwood			3706 Windom Road			Printer			Government					
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE			13b. COUNTY			13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER				
Maryland			Prince George's			Brentwood				3706 Windom Road				
14. FATHER'S NAME First Middle Last			15. MOTHER'S MAIDEN NAME First Middle Last											
Edward Sword			Gussie Cowan											
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16b. SOCIAL SECURITY NO. (If yes give number and dates of service)			17. INFORMANT ADDRESS								
Yes			WW II			George E. Sword North Beach Park, Md.								
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Heart failure</u> <u>4129</u> DUE TO, OR AS A CONSEQUENCE OF <u>Arteriosclerotic heart disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) _____ DUE TO, OR AS A CONSEQUENCE OF _____ (c) _____										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH				
										minutes		unknown		
PART 2. OTHER SIGNIFICANT CONDITIONS <u>CONTRIBUTING TO DEATH</u> BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <u>4200</u>														
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 19				21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)						
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)				21f. LOCATION Street or R.F.D. No. City or Town County State						
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>														
ACTUAL SIGNATURE <u>John Kehoe</u> M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>				22b. DATE SIGNED <u>7-14-68</u>						
EXAMINER'S NAME (Type) <u>John Kehoe MD</u>				<u>Riverdale, Md.</u>				ADDRESS (Street, city, town, or county)						
23a. BURIAL, CREMATION REMOVAL (Specify)			23b. DATE		23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION (City or Town) (County) (State)						
Burial			7/16/68		George Washington			Hyattsville P. G. Md.						
24. FUNERAL DIRECTOR ADDRESS						25a. REC'D BY REGISTRAR DATE		25b. REGISTRAR'S SIGNATURE						
Francis Gasch's Sons Hyattsville, Maryland						JUL 17 1968		<u>Charles Judge</u>						

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UNITED STATES DEPARTMENT OF THE INTERIOR

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TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

Page 2

MEDICAL CERTIFICATION

1. DECEASED-NAME (Type or Print) First Middle Last Marlin E Tate										2a. DATE KNOWN OF DEATH <input type="checkbox"/> Month Day Year ESTIMATED <input checked="" type="checkbox"/> 7-24-68 12:15am M		2b. HOUR	
3. SEX Female		4. RACE White		5. DATE OF BIRTH 21 Oct. 1936		6. AGE (In years last birthday) 31 YRS. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN		2c. DATE PRONOUNCED DEAD Month Day Year 7 24 68		2d. HOUR 2:30am M			
7a. BIRTHPLACE (State or foreign country) Nash., D.C.				7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Prince George's Md.					
10. CITY OR TOWN OF DEATH Cheverly				11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Prince George Hospital				12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Bookkeeper		12b. KIND OF BUSINESS OR INDUSTRY			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland				13b. COUNTY Prince George's Mt. Rainier				13c. CITY OR TOWN YES <input type="checkbox"/> NO <input type="checkbox"/>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>			
14. FATHER'S NAME First Middle Last Henry Lee Leister Arnold Arnold				15. MOTHER'S MAIDEN NAME First Middle Last Mary E Larrick Violet Lueve Larrick				13e. STREET AND NUMBER 3210 Upshur Street					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no				16b. SOCIAL SECURITY NO. (If yes give war or dates of service)		17. INFORMANT ADDRESS Violet L Arnold Mt Rainier, Md.							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Uremia 2509 DUE TO, OR AS A CONSEQUENCE OF Glomerulosclerosis (b) From Diabetic nephropathy DUE TO, OR AS A CONSEQUENCE OF (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH over 1 yr.			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 260X													
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)									
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No. City or Town County State									
22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE John Kehoe M.D. EXAMINER'S NAME (Type) John Kehoe MD Riverdale, Md. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> ADDRESS (Street, city, town, or county) 22b. DATE SIGNED 7-24-68													
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE July 27, 1968		23c. NAME OF CEMETERY OR CREMATORY Ft Lincoln Cemetery				23d. LOCATION (City or Town) (County) (State) Colmar Manor Pro Geo Md.					
24. FUNERAL DIRECTOR F. Gasch's Sons Hyattsville, Md.				25a. REC'D BY REGISTRAR DATE JUL 29 1968		25b. REGISTRAR'S SIGNATURE J Charles Judge							

FOR STATE
HEALTH DEPT

REPORT OF PHYSICIAN
ON DEATH

Name of Patient		Age		Sex	
Date of Birth		Date of Death		Time of Death	
Place of Birth		Place of Death		Cause of Death	
Occupation		Previous Illness		Manner of Death	
History of Present Illness		History of Past Illness		Physical Examination	
Laboratory Examinations		X-ray Examinations		Microscopic Examinations	
Treatment		Prognosis		Remarks	

DATE: JUL 28, 1966

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 12 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
<div style="display: flex; justify-content: space-between;"> 10553 CERTIFICATE OF DEATH 10562 </div>									
1. DECEASED-NAME (Type or print)						2a. DATE OF DEATH		2b. HOUR	
<div style="display: flex; justify-content: space-between;"> First Middle Last </div> Herbert C Tegeder						<div style="display: flex; justify-content: space-between;"> Month Day Year </div> July 3 1968		3,45A	
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years lost birthday)		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
Male		White		9 Mar., 1887		81		YRS.	
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH			
Balto., Md.		USA				Pr. Geo.			
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY	
Cheverly			Pr. Geo., Gen. Hosp.,						
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE				13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
Maryland				Pr., Geo.		Maryland Park		100 64th Place	
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME						
First Middle Last			First Middle Last						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes give war or dates of service)				16b. SOCIAL SECURITY NO.		17. INFORMANT Address			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Broncho-pneumonia, bilateral, lower lobes. DUE TO, OR AS A CONSEQUENCE OF (b) Stenosing coronary arteriosclerosis with old occlusion DUE TO, OR AS A CONSEQUENCE OF of the anterior descending branch of the left (c) coronary artery with old antero-septal infarct.									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a) Generalized arteriosclerosis, severe.									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
					YES <input checked="" type="checkbox"/> NO <input checked="" type="checkbox"/>		Yes.		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1B.)					
		HOUR A.M. Month Day Year P.M. 19							
21d. INJURY OCCURRED		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION		City or Town		County State	
While <input type="checkbox"/> Nat while <input type="checkbox"/> at work <input type="checkbox"/>									
22a. I certify that (I) (the hospital) attended the deceased from March 9, 1968 , to July 3, 1968 , that (I) (we) saw the deceased alive on July 3, 1968 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (do not) view the body after death.									
22b. SIGNATURE						22c. DATE SIGNED			
Peter Duus M.D. DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>									
22d. PHYSICIAN'S NAME (Type)						22e. ADDRESS			
Peter Duus, M. D.						6056 Central Ave., Capitol Hgts, Md. 20027			
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)			
Burial		July 6, 1968		Columbia Gardens Cem.		Arlington, Virginia			
24. FUNERAL DIRECTOR ADDRESS						25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	
Ives Funeral Home Arlington 1, Va.						DATE JUL - 8 1968		Charles J...	

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STATE OF TEXAS

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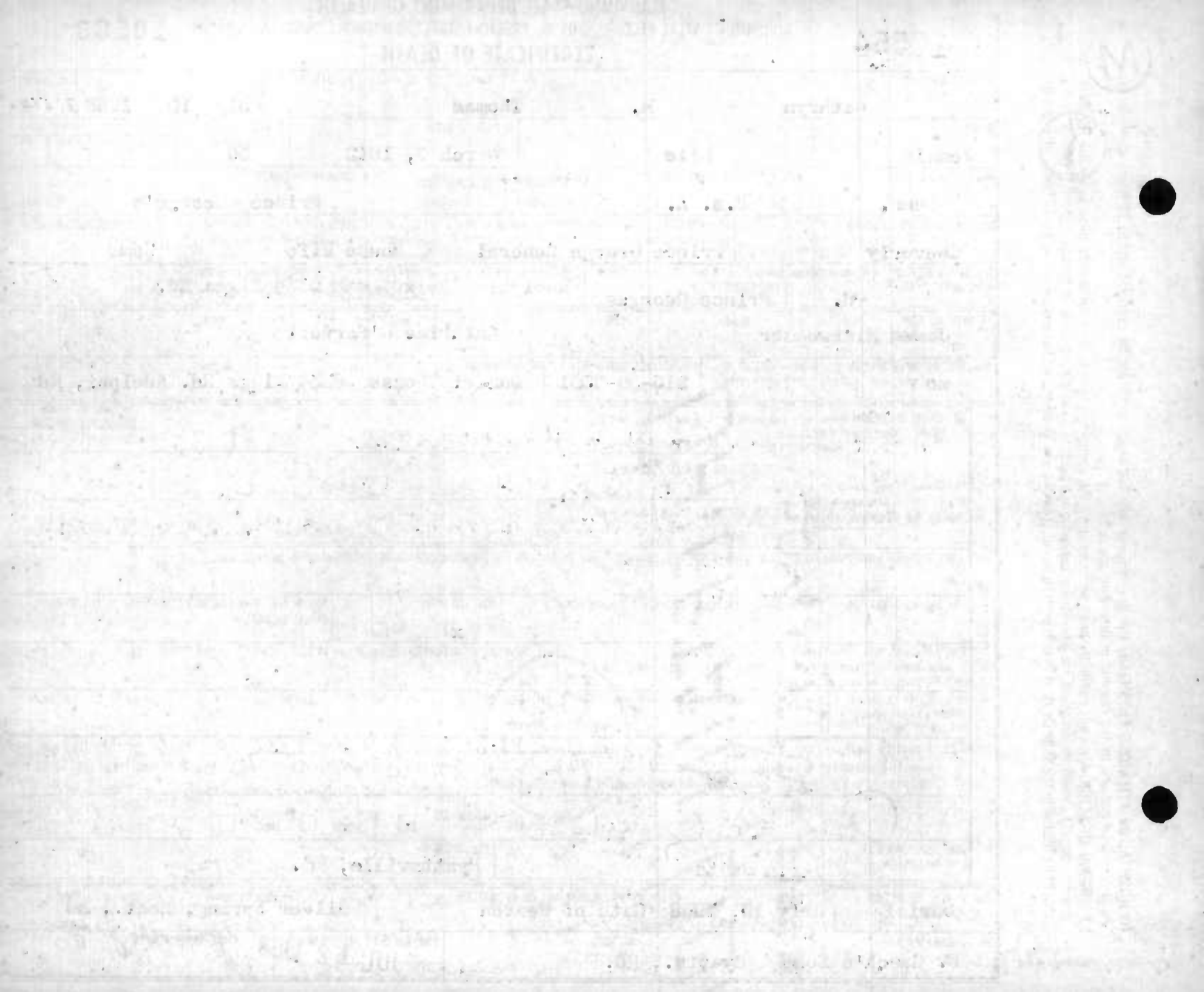
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers (pages 1 and 2) should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

10554

CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or print) Kathryn M. Thomas			2a. DATE OF DEATH Month July Day 10 Year 1968		2b. HOUR 3:54 M
3. SEX Female	4. RACE White	5. DATE OF BIRTH March 7, 1912		6. AGE (In years last birthday) 56 YRS.	IF UNDER 1 YEAR MONTHS IF UNDER 24 HRS. HOURS MIN.
7a. BIRTHPLACE (State or foreign country) Penn.	7b. CITIZEN OF WHAT COUNTRY? U.S. A.	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH Prince George's Md.		
10. CITY OR TOWN OF DEATH Cheverly	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Prince George General	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) House wife		12b. KIND OF BUSINESS OR INDUSTRY home	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Md.	13b. COUNTY Prince Georges	13c. CITY OR TOWN Adelphi	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET AND NUMBER 9234 Riggs Rd.	
14. FATHER'S NAME First Middle Last James Mineweaser			15. MOTHER'S MAIDEN NAME First Middle Last Kathrine O'Farrell		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no (If yes give war or dates of service)		16b. SOCIAL SECURITY NO. 215-20-3561		17. INFORMANT Address Daniel Thomas 9234 Riggs Rd. Adelphi, Md	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Heart Failure 3960 DUE TO, OR AS A CONSEQUENCE OF (b) Rheumatic Heart Disease DUE TO, OR AS A CONSEQUENCE OF (c) Valvular Stenosis & Aortic Regurgitation Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) 410X					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)	
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State	
22a. I certify that (I) (this hospital) attended the deceased from June 2, 1968 to July 10, 1968 , that (I) (we) last saw the deceased alive on June 9, 1968 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) did (did not) view the body after death.					
22b. SIGNATURE Aaron Deitz		DEGREE MD		22c. DATE SIGNED 7-10-68	
22d. PHYSICIAN'S NAME (Type) Aaron Deitz		22e. ADDRESS Hyattsville, Md.			
23a. BURIAL, CREMATION, REBURY Reburied		23b. DATE July 13, 1968		23c. NAME OF CEMETERY OR CREMATORY Gate of Heaven	
23d. LOCATION (City or Town) (County) (State) Silver Spring, Mont., Md		23e. LOCATION (City or Town) (County) (State) Silver Spring, Mont., Md			
24. FUNERAL DIRECTOR F. Gasch's Sons		ADDRESS Hyatts., Md.		25a. REC'D BY REGISTRAR JUL 12 1968	
25b. REGISTRAR'S SIGNATURE [Signature]		25c. REGISTRAR'S SIGNATURE [Signature]			



CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or print) William E. Thomas			2a. DATE OF DEATH Month 7 Day 8 Year 68			2b. HOUR 11:20 AM	
3. SEX Male		4. RACE White		5. DATE OF BIRTH 9/20/13		6. AGE (In years lost birthday) 54 YRS.	
7a. BIRTHPLACE (State or foreign country) Va.		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Prince George's Md.	
10. CITY OR TOWN OF DEATH Riverdale		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give address) Veterans Memorial Hospital		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Printing		12b. KIND OF BUSINESS OR INDUSTRY Dept of Arm	
13a. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) STATE Md.		13b. COUNTY P. G.		13c. CITY OR TOWN Carrollton		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME Charles Thomas		15. MOTHER'S MAIDEN NAME Lillian Leigh		13e. STREET AND NUMBER 5503 Karen Elaine Dr.			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, No or unknown		16b. SOCIAL SECURITY NO. 577-14-3854		17. INFORMANT Marie L. Thomas 6700 Belcrest Rd. Hyatts. Md.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Ac Myocardial Failure</i> 1621 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <i>Metastatic carcinoma (Blung)</i> DUE TO, OR AS A CONSEQUENCE OF (c) PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) 163X							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that (I) (this hospital attended the deceased from June 68, to July 68, that (I) (we) last saw the deceased alive on July 68 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <i>U.L. Etienne</i>		22c. DATE SIGNED 7/8/68		22d. PHYSICIAN'S NAME (Type) U.L. ETIENNE			
22e. ADDRESS <i>College Park, Md.</i>		22f. DEGREE DEGREE		22g. MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22h. DATE SIGNED 7/8/68	
23a. BURIAL, CREMATION, REINTERMENT Burial		23b. DATE 7-11-68		23c. NAME OF CEMETERY OR CREMATORY George Washington Cem.		23d. LOCATION (City or Town) (County) (State) Hyattsville, Md.	
24. FUNERAL DIRECTOR F. Gasch's Sons 4739 Balt. Ave. Hyattsville, Md.				25a. REC'D BY REGISTRAR JUL 11 1968		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

Metropolitan Government
of Philadelphia

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W. L. E. E. E. E. E.
George Taylor
18th St
18th St

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form BM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
10556									
Item #5, Film GL02 7/1 MEDICAL EXAMINER'S CERTIFICATE OF DEATH									
1. DECEASED NAME (Type or Print) First Middle Last JOHN ALLEN TRUPE						2a. DATE KNOWN OF DEATH Month Day Year July 7 1968		2b. HOUR 1030 A.M.	
3. SEX M	4. RACE W	5. DATE OF BIRTH Oct 30 1926	6. AGE (In years last birthday) 41 YRS.	IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.	2c. DATE PRONOUNCED DEAD Month Day Year July 7 1968		2d. HOUR 1030 A.M.	
7a. BIRTHPLACE (State or foreign country) Ohio USA		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Prince Georges		Md.	
10. CITY OR TOWN OF DEATH Riverdale		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Eugene Leeland Memorial		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Pipe Fitter		12b. KIND OF BUSINESS OR INDUSTRY Building			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Md		13b. COUNTY Pr Geo		13c. CITY OR TOWN Brentwood		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 3808-37 Rd	
14. FATHER'S NAME First Middle Last Charles H Trupe			15. MOTHER'S MAIDEN NAME First Middle Last Elizabeth Moninger						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes			16b. SOCIAL SECURITY NO. 282 229575			17. INFORMATION ADDRESS 3808-37 Rd Brentwood Md			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Respiratory arrest due to General (Pneumonia) 513 X DUE TO OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: General Respiration from Bronchitis and few mites DUE TO OR AS A CONSEQUENCE OF Multiple de Pulmonary Abscesses at lung/organism 521 X PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 521 X									
19a. DATE OF OPERATION 7-7-68		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? Hemastomy - Multiple de Pulmonary abscesses				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. EXTERNAL CAUSE PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY Month, Day, Year HOUR A.M. 1030 P.M. 7-7 1968		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) Respiratory arrest during anesthesia					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input checked="" type="checkbox"/> NOT WHILE AT WORK		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) Hospital		21f. LOCATION Street or R.F.D. No. City or Town County Eugene Leeland Memorial Riverdale Md					
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>									
ACTUAL SIGNATURE DAYTON O WATKINS		EXAMINER'S NAME (Type) DAYTON O WATKINS		CHIEF MEDICAL EXAMINER <input type="checkbox"/> 7-7-68 M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> 5318 Annapolis Rd		22b. DATE SIGNED Bladensburg Md			
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE 7-13-1968		23c. NAME OF CEMETERY OR CREMATORY Greenwood Corn.		23d. LOCATION (City or Town) (County) (State) TRUMBULL Co Ohio			
24. FUNERAL DIRECTOR W.W. Chambers Co. Riverdale, Md.				25a. REC'D BY REGISTRAR JUL 10 1968		25b. REGISTRAR'S SIGNATURE J Charles Judge			

TO THE SECRETARY OF THE LAND OFFICE
WASHINGTON, D.C.

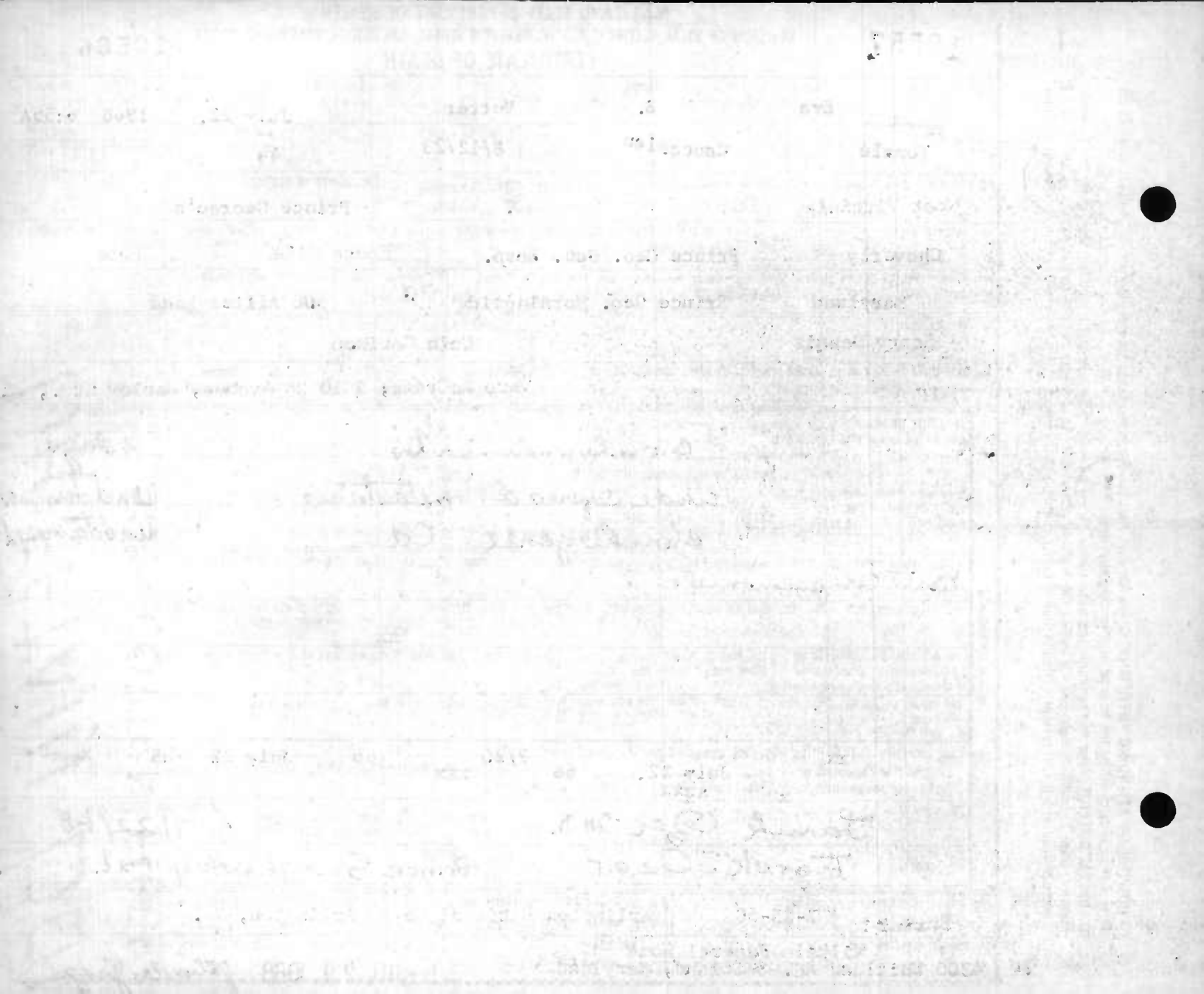
SIR:

I have the honor to acknowledge the receipt of your letter of the 10th inst. in relation to the above entitled matter.

I am, Sir, very respectfully,
Yours, very obediently,
J. M. [Signature]

1
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
1
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 7 hours after death.

1. DECEASED-NAME (Type or print)		First	Middle	Last	2a. DATE OF DEATH		2b. HOUR	
Eva		B.	Vetter	Month	Day	Year	6:55A ^M	
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)		7. IF UNDER 1 YEAR
Female		Caucasian		8/12/23		44 YRS.		MONTHS
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH		12b. KIND OF BUSINESS OR INDUSTRY
West Virginia		USA				Prince George's		Home
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY		
Cheverly		Prince Geo. Gen. Hosp.		house wife				
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER
Maryland		Prince Geo.		Morningside				508 Allies Road
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, <input type="checkbox"/> No, <input checked="" type="checkbox"/> (If yes give war or dates of service)		16b. SOCIAL SECURITY NO.		17. INFORMANT
Henry Dennis		Ocie Garrison						Vera DaCrema, 5910 28 Avenue, Marlow Hts., Md.
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
PART I. DEATH WAS CAUSED BY:								
IMMEDIATE CAUSE (a) <u>Bronchopneumonitis</u>								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
1621								2 days.
DUE TO, OR AS A CONSEQUENCE OF								
(b) <u>Wide spread metastasis</u>								Undetermined
DUE TO, OR AS A CONSEQUENCE OF								
(c) <u>Bronchogenic Ca.</u>								Undetermined
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a)								
<u>Acute or pulmonale</u>								
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)				
		HOUR A.M. Month Day Year						
21d. INJURY OCCURRED		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION		21g. CITY OR TOWN		21h. COUNTY
While <input type="checkbox"/> Not while <input type="checkbox"/>				Street or R.F.D. No.		City or Town		County
at work <input type="checkbox"/> at work <input type="checkbox"/>								State
22a. I certify that (I) (this hospital) attended the deceased from <u>7/20</u> , 19 <u>68</u> , to <u>July 22</u> , 19 <u>68</u> , that (I) (we) lost								
saw the deceased alive on <u>July 22</u> , 19 <u>68</u> , and that in my (our) opinion death occurred on the date and hour and from the								
causes stated above, (I) (we) (did) (did not) view the body after death.								
22b. SIGNATURE		22c. DATE SIGNED		22d. PHYSICIAN'S NAME (Type)		22e. ADDRESS		
Faruk Ozer M.D.		7/22/68		Faruk Ozer		Prince George's Hospital		
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town)		23e. (County) (State)
Burial		7-25-68		Arlington National Cem		Arlington, Va.		
24. FUNERAL DIRECTOR		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE				
Wilhelm Funeral Home		DATE JUL 29 1968		f Charles Judge				
4308 Suitland Rd. Suitland, Maryland								



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (1-64)
30M REV. 7-55

10558				DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201				10567				
tem#9 Film#G402 7/23/68 vmp				CERTIFICATE OF DEATH								
1. DECEASED-NAME (Type or print)			First Middle Last			2a. DATE OF DEATH Month Day Year			2b. HOUR			
Charles Stanley Walters						July 9 1968			11:25AM			
3. SEX		4. RACE		5. DATE OF BIRTH			6. AGE (In years last birthday)		IF UNDER 1 YEAR		IF UNDER 24 HRS.	
Male		White		June 14, 1912			56 YRS.		MONTHS DAYS		HOURS MIN	
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH					
Chicago, Ill.		U.S.A.					Montgomery Prince George's Md.					
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)			12b. KIND OF BUSINESS OR INDUSTRY.			
Takoma Park			902 Elm Avenue			Retired Printer 400 ft.			Printing Off			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE			13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER			
Md.			Montgomery		Takoma Park				902 Elm Avenue			
14. FATHER'S NAME First Middle Last			15. MOTHER'S MAIDEN NAME First Middle Last									
Gus Perry Walters			Ella Mae Stanley									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown (If yes, give war or dates of service)			16b. SOCIAL SECURITY NO.		17. INFORMANT							
Yes			214-24-1389		Michael S. Walters 4407 Ramon Street, Beltsville, Md.							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 1532 Carcinomatosis										6 mos		
DUE TO, OR AS A CONSEQUENCE OF (b) Acleno Ca left colon										5 yrs		
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c)												
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (o)												
1532												
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No.		City or Town		County		State	
22a. I certify that (I) (this hospital) attended the deceased from 12-14, 1967, to 7-9, 1968, that (I) (we) last saw the deceased alive on 7-6, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. 11:25 am												
22b. SIGNATURE Joanne C. Bateman MD					DEGREE		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED 7-10-68			
22d. PHYSICIAN'S NAME (Type) Dr. Joanne C. Bateman					22e. ADDRESS 312 So. Wash. St. Alexandria, Va.							
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE July 13, 1968		23c. NAME OF CEMETERY OR CREMATORY Gate of Heaven Cemetery			23d. LOCATION (City or Town) Silver Spring, Maryland		(County) (State)			
24. FUNERAL DIRECTOR W. Lee Lee Warner C. Humphrey, Inc.					ADDRESS 8434 Georgia Avenue Silver Spring, Md.		25a. REC'D BY REGISTRAR DATE JUL 17 1968		25b. REGISTRAR'S SIGNATURE Charles Judge			

11

(continued)

10559

10568

1. DECEASED NAME (Type or print)		First		Middle		Last		2a. DATE OF DEATH				2b. HOUR			
James				Wamsley				Month Day Year July 6, 1968				3:10			
3. SEX		4. RACE		5. DATE OF BIRTH				6. AGE (In years last birthday)		IF UNDER 1 YEAR		IF UNDER 24 HRS.			
Male		White		11/1/07				68 60 YRS.		MONTHS DAYS		HOURS MIN.			
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH						Md			
Virginia		USA				Prince George									
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)				12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)				12b. KIND OF BUSINESS OR INDUSTRY					
Cheverly		Prince Georges Hospital				Restaurant Operator									
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET AND NUMBER							
STATE Maryland		Prince Geo		Mt Rainier		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		3123 Queens Chapel Road							
14. FATHER'S NAME		First		Middle		Last		15. MOTHER'S MAIDEN NAME		First		Middle		Last	
Walter		-		Wamsley				Fannie		-		Duffey			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16b. SOCIAL SECURITY NO.		17. INFORMANT				Address							
No		577 05 1979		Althea Blaylock				2412 36th St SE Wash DC							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
PART 1. DEATH WAS CAUSED BY:															
IMMEDIATE CAUSE (a) Cerebellar Thrombosis															
4339 DUE TO, OR AS A CONSEQUENCE OF															
(b) Cerebral Arteriosclerosis															
DUE TO, OR AS A CONSEQUENCE OF															
(c)															
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)															
332x															
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY?		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?							
						YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>									
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)											
HOUR A.M. Month Day Year		P.M. 19													
21d. INJURY OCCURRED		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION		City or Town		County		State					
While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>															
22a. I certify that (I) (the hospital) attended the deceased from July 2, 1968, to July 6, 1968, that (I) (we) lost the deceased alive on July 6, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.															
22b. SIGNATURE		22c. DATE SIGNED													
O. Sahakyan															
22d. PHYSICIAN'S NAME (Type)		22e. ADDRESS													
		6001 Landover Rd., Cheverly, Md.													
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town)		(County)		(State)					
Burial		7-9-1968		Fort Lincoln Cemetery		Bladensburg		PG		Maryland					
24. FUNERAL DIRECTOR						25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE							
Robert E. Wilhelm Funeral Home						DATE		JUL 16 1968							
4308 Suitland Road Suitland Maryland								J. Charles Judge							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. ~~The~~ He ~~people~~ he remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
30M REV. 11-68

11

THE UNIVERSITY OF CHICAGO

DEPARTMENT OF CHEMISTRY

1950

RECEIVED
JAN 10 1950
DEPT. OF CHEMISTRY
UNIVERSITY OF CHICAGO
CHICAGO, ILL.
FROM: [illegible]
SUBJECT: [illegible]
[The remainder of the page contains extremely faint, mostly illegible text, likely bleed-through from the reverse side of the document.]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 and should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										
CERTIFICATE OF DEATH										
1. DECEASED-NAME (Type or print) Roger N. Wells			2a. DATE OF DEATH Month 7 Day 3 Year 68			2b. HOUR 4:38p				
3. SEX Male		4. RACE White		5. DATE OF BIRTH 7-18-12		6. AGE (In years last birthday) 55 YRS.		IF UNDER 1 YEAR MONTHS DAYS 		IF UNDER 24 HRS. HOURS MIN
7a. BIRTHPLACE (State or foreign country) Virginia		7b. CITIZEN OF WHAT COUNTRY? United States		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Prince George's County Md.				
10. CITY OR TOWN OF DEATH Cheverly		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Prince George's General			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Electrician			12b. KIND OF BUSINESS OR INDUSTRY		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Md.		13b. COUNTY Prince George's		13c. CITY OR TOWN Brentwood		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 4102 Parkwood Street		
14. FATHER'S NAME First James Middle W. Last Wells			15. MOTHER'S MAIDEN NAME First Julia Middle Elizabeth Last Nicholas							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) No		16b. SOCIAL SECURITY NO. 579-03-0438		17. INFORMANT Address Daughter Sylvia Holtz Same as above						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinomatous 1621 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Carcinoma / Lung. DUE TO, OR AS A CONSEQUENCE OF (c)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (o) 163x										
19a. DATE OF OPERATION NA		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED NA			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) NA		21b. TIME OF INJURY HOUR A.M. NA Month NA Day NA Year 19 P.M. NA		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) NA						
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input checked="" type="checkbox"/> Not at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) NA		21f. LOCATION Street or R.F.D. No. NA City or Town NA County NA State NA						
22a. I certify that (I) (this hospital) attended the deceased from 6/6/68 , 19 68 , to 7/3 , 19 68 , that (I) (we) last saw the deceased alive on 7/3 , 19 68 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE Barry Rosenberg				22c. DATE SIGNED 7/6/68		22d. PHYSICIAN'S NAME (Type) Barry Rosenberg, M.D.		22e. ADDRESS 6501 Landover Road, Cheverly, Md. 20785		
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 7/6/68		23c. NAME OF CEMETERY OR CREMATORY Woodfield Cemetery		23d. LOCATION (City or Town) (County) (State) Galesville Maryland		23e. REGISTRAR'S SIGNATURE Charles Judge		
24. FUNERAL DIRECTOR F. Gasch's Sons		24b. ADDRESS Hyattsville, Maryland		24c. REC'D BY REGISTRAR JUL - 8 1968		24d. REGISTRAR'S SIGNATURE Charles Judge				

1955

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DATE

BY

REMARKS

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1-13-55

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2, should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (1)
30M REV. 1/68

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
CERTIFICATE OF DEATH									
1. DECEASED-NAME (Type or print)			First Middle Last			2a. DATE OF DEATH Month Day Year			2b. HOUR
George B. White						July 2, 1968			7:30A ^M
3. SEX	4. RACE		5. DATE OF BIRTH			6. AGE (In years last birthday)		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
Male	Caucasian		12/3/03			64 YRS.			
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH			
MARYLAND		U.S.A.				Prince George's Md.			
1d. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)			12b. KIND OF BUSINESS OR INDUSTRY	
Cheverly		Prince Geo.Gen'l Hospital			FARMER			TOBACCO	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE			13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER
Maryland			Prince George's		Clinton		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		7635 Lohr Lane
14. FATHER'S NAME First Middle Last			15. MOTHER'S MAIDEN NAME First Middle Last						
LEE WHITE			NETTA PAYNE						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown			16b. SOCIAL SECURITY NO.		17. INFORMANT Address				
NO			220-05-7602		JUNE RIDDLE, CLINTON, M.D.				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardio-respiratory failure.</u> <u>185X</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Metastatic brain lesion</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>carcinoma of the prostate.</u>									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) <u>177X</u>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <u>May 20, 1968</u> , to <u>July 2, 1968</u> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <u>July 2, 1968</u> , and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above, <input checked="" type="checkbox"/> (we) (did) (did not) view the body after death.									
22b. SIGNATURE <u>Josefino Ceballos</u> DEGREE					ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22c. DATE SIGNED July 2, 1968		
22d. PHYSICIAN'S NAME (Type) Josefino Ceballos, M. D.					22e. ADDRESS Prince George's General Hospital, Cheverly				
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County)		Maryland	
BURIAL		7-5-68		BELLS METH CEM.		CAMP SPRINGS		MD.	
24. FUNERAL HOME ADDRESS					25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE		
HUNTT FUNERAL HOME, WALDORF, MD.					DATE JUL - 8 1968		<u>Charles Judge</u>		

5950

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

10562

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10571

1. DECEASED-NAME (Type or Print) First Thomas Middle Earl Last White				2a. DATE KNOWN OF DEATH <input type="checkbox"/> Month <input type="checkbox"/> Day <input type="checkbox"/> Year <input checked="" type="checkbox"/> 7-14-68 19 9 : 25 pm		2b. HOUR	
3. SEX Male	4. RACE White	5. DATE OF BIRTH 10-10-1946	6. AGE (In years last birthday) 21 YRS.	IF UNDER 1 YEAR MONTHS <input type="checkbox"/> DAYS <input type="checkbox"/>	IF UNDER 24 HRS. HOURS <input type="checkbox"/> MIN. <input type="checkbox"/>	2c. DATE PRONOUNCED DEAD Month 7 Day 14 Year 68 19 9 : 59 pm	
7a. BIRTHPLACE (State or foreign country) Maryland		7b. CITIZEN OF WHAT COUNTRY? U. S. A.		8. MARRIED NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Prince George's Md.	
10. CITY OR TOWN OF DEATH Cheverly		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Prince George Hospital		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) 2nd Class Petty Officer		12b. KIND OF BUSINESS OR INDUSTRY U.S. Navy	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland		13b. COUNTY Prince George's		13c. CITY OR TOWN Mitchelville		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME First Middle Last Thomas A. White		15. MOTHER'S MAIDEN NAME First Middle Last Ruth -- Catterton		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes (If yes give war or dates of service)		16b. SOCIAL SECURITY NO. 213-46-6604	
17. INFORMANT Mrs. Ruth Catterton Richards		ADDRESS Same as		17. INFORMANT Mrs. Ruth Catterton Richards		17. INFORMANT 13-a-c.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Laceration of brain 8120 DUE TO, OR AS A CONSEQUENCE OF Skull fracture Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) From trauma - auto accident DUE TO, OR AS A CONSEQUENCE OF (c)							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 8164							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY Month, Day, Year HOUR A.M. 9:25pm 7-14-19 68		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1B.) Driver of car involved in collision.			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) Queen Anne Road and Route # 214,		21f. LOCATION Street or R.F.D. No. City or Town County State Pr. Geo Maryland			
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE EXAMINER'S NAME (Type) John Kehoe MD		M.D. Riverdale, Md.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		22b. DATE SIGNED 7-15-68	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 7/18/68		23c. NAME OF CEMETERY OR CREMATORY Mt. Calvary Methodist Cemetery		23d. LOCATION (City or Town) (County) (State) Lothian A.A. Md.	
24. FUNERAL DIRECTOR Ritchie Bros. Upper Marlboro, Md.				25a. REC'D BY REGISTRAR DATE JUL 24 1968		25b. REGISTRAR'S SIGNATURE Charles Judge	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

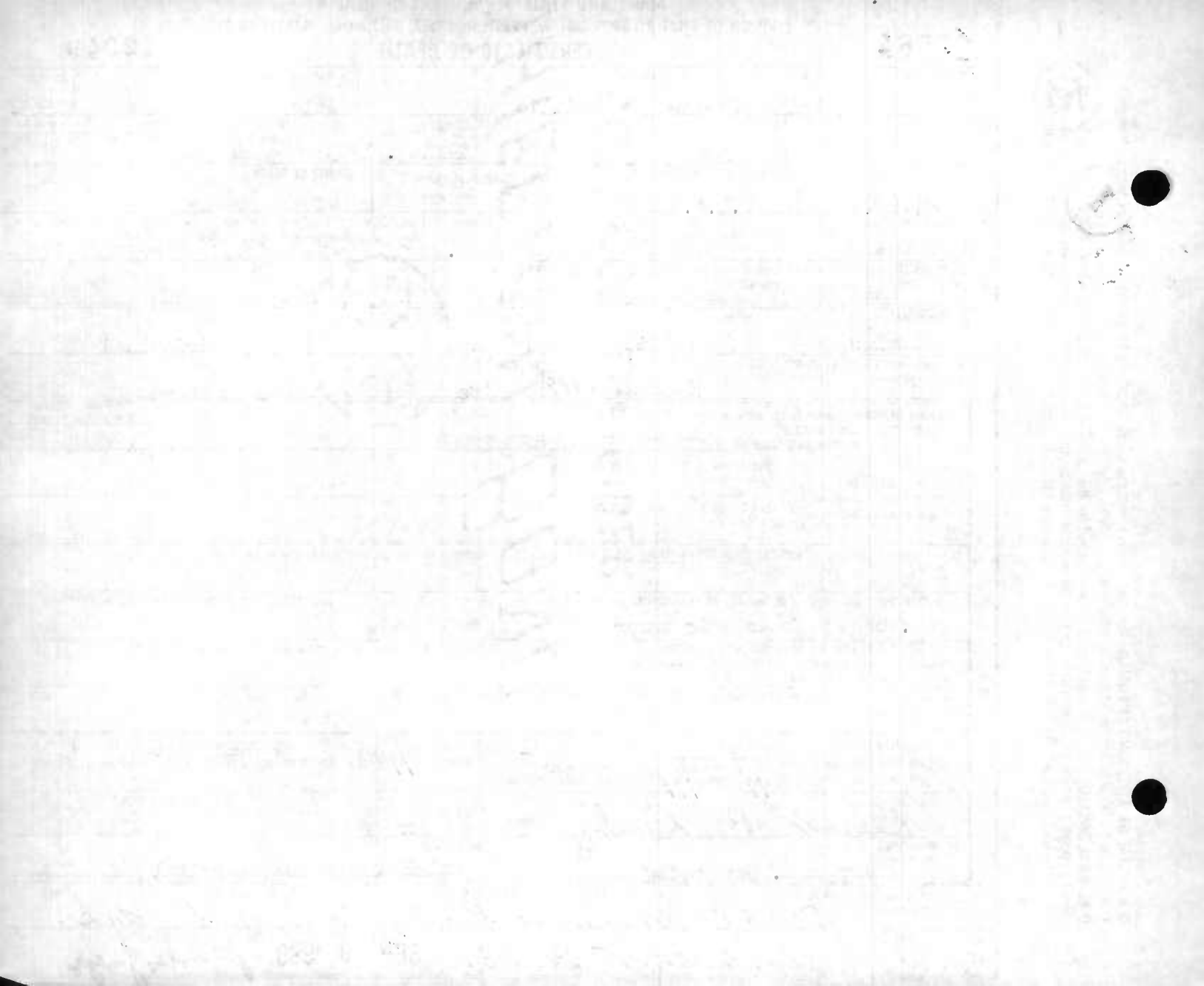
VR 151
30M REV. 1-68

10563		DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201				10572	
CERTIFICATE OF DEATH							
1. DECEASED-NAME (Type or print) First Middle Last Walker Guy Willett				2a. DATE OF DEATH Month Day Year July 24 1968		2b. HOUR 5:30 AM	
3. SEX Male		4. RACE White		5. DATE OF BIRTH 5-30-03		6. AGE (In years last birthday) 65 YRS.	
7a. BIRTHPLACE (State or foreign country) Maryland		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Prince George Md.	
10. CITY OR TOWN OF DEATH Clinton		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Pine View Gardens		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Farmer		12b. KIND OF BUSINESS OR INDUSTRY TOBACCO	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland		13b. COUNTY Prince George		13c. CITY OR TOWN Accokeek		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
13e. STREET AND NUMBER Box 41		14. FATHER'S NAME First Middle Last D Guy Willett		15. MOTHER'S MAIDEN NAME First Middle Last VIRGIE IRENE Pickerell			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown No		16b. SOCIAL SECURITY NO. 212-10-3996		17. INFORMANT MRS. Walker Willett		Address Accokeek Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac Arrest</u> <u>185X</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <u>177X</u> (b) <u>Terminal CA with Metastases</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Prostatic CA</u>						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) <u>Diabetic</u>							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from <u>7-18</u> , 19 <u>68</u> , to <u>7-24</u> , 19 <u>68</u> , that (I) (we) last saw the deceased alive on <u>7-24</u> , 19 <u>68</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <u>Alfred R. Lapin MD</u>				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED <u>7-24-68</u>	
22d. PHYSICIAN'S NAME (Type) <u>ALFRED R. LAPIN MD</u>				22e. ADDRESS <u>CLINTON, MD</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE <u>7-27-68</u>		23c. NAME OF CEMETERY OR CREMATORY <u>CHRIST CHURCH ACCOKEEK OR. GEO. MD</u>		23d. LOCATION (City or Town) (County) (State) <u>Clinton, Md.</u>	
24. FUNERAL DIRECTOR <u>Hunt Funeral Home, Waldorf, Md.</u>				25a. REC'D BY REGISTRAR DATE <u>JUL 29 1968</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
10564									
CERTIFICATE OF DEATH									
12049									
1. DECEASED-NAME (Type or print)			First Middle Last			2a. DATE OF DEATH Month Day Year		2b. HOUR	
Fairice Victor			Willie			July 7		1968 1545	
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years lost birthday)		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
MALE		CAU		11 Aug. 1923		44 YRS.			
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH		Md.	
ARK.		U.S.A.				PRINCE GEORGES			
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY			
ANDREWS AFB		MALCOLM GROW USAF HOSP.		Hon. Com. Officer		MILITARY			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER	
MARYLAND		PRINCE GEORGE		SUITLAND		YES		1628 HOWE AVE	
14. FATHER'S NAME First Middle Last			15. MOTHER'S MAIDEN NAME First Middle Last						
Charles Willie			Ann Strickland						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16b. SOCIAL SECURITY NO.		17. INFORMANT		Address			
YES		432-26-2489		Wife		Same as Above			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>237.6 METASTATIC BLADDER TUMOR</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO, OR AS A CONSEQUENCE OF (c)								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 YEAR	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) 236X									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
FEB. 68		Metastatic tumor		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION		Street or R.F.D. No.		City or Town County State	
22a. I certify that (I) (this hospital) attended the deceased from <u>1 OCT</u> , 19 <u>67</u> , to <u>7 JULY</u> , 19 <u>68</u> , that (I) (we) last saw the deceased alive on <u>7 JULY</u> , 19 <u>68</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE Dennis R. Derby						DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED 7 JULY 68	
22d. PHYSICIAN'S NAME (Type) Dennis R. Derby Maj						22e. ADDRESS Malcolm Grow USAF Hospital			
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)			
		7-9-68		Memorial Garden		Paragould Ark.			
24. FUNERAL DIRECTOR W. W. Chambers Co. 517-11th St. S.E.						25a. REC'D BY REGISTRAR SEP 9 1968		25b. REGISTRAR'S SIGNATURE Charles Judge	



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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2, should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

10565

10573

1. DECEASED-NAME (Type or print)		First Joseph	Middle Kent	Last Wilson	2a. DATE OF DEATH July Month 10 , Day 1968 Year		2b. HOUR 7:25 P M			
3. SEX Male		4. RACE Caucasian		5. DATE OF BIRTH 12/25/1900		6. AGE (In years last birthday) 67 YRS.		IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (State or foreign country) Maryland		7b. CITIZEN OF WHAT COUNTRY? U. S. A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Prince George's			Md.	
10. CITY OR TOWN OF DEATH Cheverly		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Prince Geo. Gen'l Hospital		12a. USUAL OCCUPATION (Kind of work done during last working life, even if retired.) Farmer		12b. KIND OF BUSINESS OR INDUSTRY Self				
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland		13b. COUNTY Prince George's		13c. CITY OR TOWN Landover		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 8525 Sheriff Rd.		
14. FATHER'S NAME First Joseph Middle Perry Last Wilson		15. MOTHER'S MAIDEN NAME First Georgie Middle Wallis Last Wallis								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> or unknown <input type="checkbox"/> (If yes give war or dates of service)		16b. SOCIAL SECURITY NO.		17. INFORMANT John N. Wilson					8421 Sheriff Road Landover, Maryland	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bilateral Pulmonary Thrombo-embolii. 4270 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Congestive Heart failure. DUE TO, OR AS A CONSEQUENCE OF (c)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 4341 Right subdural Hemorrhage.										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)						
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State						
22a. I certify that (I) did not attended the deceased from July 5 , 19 68 , to July 10 , 19 68 , that (I) was last saw the deceased alive on July 10 , 19 68 , and that in (my) own opinion death occurred on the date and hour and from the causes stated above, (I) was (did) not view the body after death.										
22b. SIGNATURE Don B. Cameron		DEGREE MD		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED July 11, 1968				
22d. PHYSICIAN'S NAME (Type) Don B. Cameron, M. D.		22e. ADDRESS 3503 Perry St. Mt. Rainier, Maryland								
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 7/13/68		23c. NAME OF CEMETERY OR CREMATORY Mt. Carmel		23d. LOCATION (City or Town) (County) (State) Upper Marlboro P. G. Md.				
24. FUNERAL DIRECTOR Francis Gasch's Sons		ADDRESS Hyattsville, Md.		25a. REC'D BY REGISTRAR DATE JUL 15 1968		25b. REGISTRAR'S SIGNATURE Charles Judge				

15773

15773



July 10, 1958

11/25/1900

Prince George's

Prince George's

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
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DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
10566						10574					
1. PLACE OF DEATH						2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)					
a. COUNTY <u>R. Geo. Co.</u> MARYLAND						a. STATE <u>Md.</u> b. COUNTY <u>R. Geo.</u>					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Lanham, Md.</u>						c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>LANHAM</u>					
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>9920 Buena Vista Ave</u>						d. STREET ADDRESS <u>9920 Buena Vista Ave.</u>					
3. NAME OF DECEASED (Type or print)						4. DATE OF DEATH					
First Middle Last <u>John E Winston</u>						Month Day Year <u>7 10 1968</u>					
5. SEX <u>M.</u>		6. COLOR OR RACE <u>Col</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>OCT, 1874</u>		9. AGE (In years last birthday) <u>93</u> yrs.		IF UNDER 1 YEAR Months Days	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Farm</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>					
13. FATHER'S NAME <u>James Winston</u>						14. MOTHER'S MAIDEN NAME <u>Mollie P</u>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) <u>NO</u>						16. SOCIAL SECURITY NO. <u>231 48 1599</u>					
17. INFORMANT <u>Rosie W. Baugh</u>						Address <u>9920 B.V. Ave</u>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)											
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>ASHD</u> 4139 DUE TO Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. } DUE TO <u>Generalized Arteriosclerosis</u> (c)											
INTERVAL BETWEEN ONSET AND DEATH <u>10 yr</u> <u>20 yrs</u>											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>4200</u>											
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)											
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)											
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>				20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <u>Jan 7/10/68</u> 19 <u>68</u> to <u>7/10/68</u> 19 <u>68</u> , that (I) (<u>we</u>) last saw the deceased alive on <u>7/10/68</u> and that death occurred at <u>M.</u> from the causes and on the date stated above.											
22a. SIGNATURE <u>Henry A. Wise Jr</u> M.D.						ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED			
22c. PHYSICIAN'S NAME (Type) <u>Henry A. Wise, Jr.</u>						22d. ADDRESS <u>9005 Volta St Lanham, Md</u>					
23a. BURIAL CREMATION, 23b. DATE THEREOF REMOVAL (Specify) <u>7-13-68</u>				23c. NAME OF CEMETERY OR CREMATORY <u>Co. Line Bapt. Ch.</u>				23d. LOCATION (City, town or county) (State) <u>Hodensville Md.</u>			
24 FUNERAL DIRECTOR'S SIGNATURE <u>H.S. Washington & Sons</u>						ADDRESS <u>4925 Deane Ave NE</u>		25a. REC'D BY REGISTRAR <u>JUL 15 1968</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

1077

RECEIVED

1077



Generalized Anterograde Amnesia

ASAD

10/1/68

Henry A. Wise, Jr.
1000 10th St. N.W.
Washington, D.C. 20004

10/1/68

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form RM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

10567

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

10575

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or Print) ROY WASHINGTON WOLFE			2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> Month <input checked="" type="checkbox"/> Day <input checked="" type="checkbox"/> Year July 2 1968			2b. HOUR 8:30 AM		
3. SEX M	4. RACE W	5. DATE OF BIRTH April 13 1904	6. AGE (In years last birthday) 64 YRS.	IF UNDER 1 YEAR MONTHS <input type="checkbox"/> DAYS <input type="checkbox"/>	IF UNDER 24 HRS. HOURS <input type="checkbox"/> MIN <input type="checkbox"/>	2c. DATE PRONOUNCED DEAD Month July Day 3 Year 1968		
7a. BIRTHPLACE (State or foreign country) Maryland		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Prince Georges Md.		
10. CITY OR TOWN OF DEATH Cheverly		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Prince Georges General Hospital		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) residential		12b. KIND OF BUSINESS OR INDUSTRY tugboat		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE MD		13b. COUNTY Prince Georges		13c. CITY OR TOWN Bowie		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 1300 C - 68T
14. FATHER'S NAME First Edwin Middle Foreman Last Wolfe			15. MOTHER'S MAIDEN NAME First Helen Middle Elizabeth Last Conway			16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		
			16b. SOCIAL SECURITY NO. 4109			17. INFORMANT Sister Margaret Payne Bowie ADDRESS 1300 C - 68T		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Thrombosis occlusion DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. of Right Coronary artery few miles (b) of Right Coronary artery few miles DUE TO, OR AS A CONSEQUENCE OF (c) of Right Coronary artery few miles								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(c) 4201								
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?			20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY Month, Day, Year HOUR A.M. 19 P.M.		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)				
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No. City or Town County State				
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>								
ACTUAL SIGNATURE Dayton Watkins			CHIEF MEDICAL EXAMINER <input type="checkbox"/>			22b. DATE SIGNED 7-3-68		
EXAMINER'S NAME (Type) DAYTON O WATKINS			ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> 5318 Annapolis Rd		
			ADDRESS (Street, city, town, or county) Bladenboro Md					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 7-6-68		23c. NAME OF CEMETERY OR CREMATORY Glen Haven Mem Park		23d. LOCATION (City or Town) (County) (State) Glen Burnie Md.		
24. FUNERAL DIRECTOR Dr. Will Donaldson Laurel, Md				25a. REC'D BY REGISTRAR JUL - 9 1968		25b. REGISTRAR'S SIGNATURE Charles Judge		

100-100000

UNITED STATES DEPARTMENT OF JUSTICE
FEDERAL BUREAU OF INVESTIGATION
WASHINGTON, D. C. 20535

100-100000



100-100000

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

10568

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10576

1. DECEASED-NAME (Type or Print)			First Middle Last			2a. DATE KNOWN OF ESTI- DEATH MATED <input checked="" type="checkbox"/> 7-14-68			2b. HOUR 18:30pm M		
Frank			M			Wood Sr.					
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (In years last birthday)	IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.		2c. DATE PRONOUNCED DEAD Month Day Year			2d. HOUR
Male	White	7-3-1899	69 YRS.					7 14 68			8:47pm M
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Prince George's Md.					
Virginia		U.S.A.									
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)			12b. KIND OF BUSINESS OR INDUSTRY		
Cheverly			Prince George Hospital			CARPENTER			Construction		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE				13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER	
Maryland				Prince George's		Beltsville		YES <input type="checkbox"/> NO <input type="checkbox"/>		6821 Beaver Dam Road	
14. FATHER'S NAME First Middle Last				15. MOTHER'S MAIDEN NAME First Middle Last							
JAMES				Wood				UNKNOWN			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)				16b. SOCIAL SECURITY NO.		17. INFORMANT					
No				578-03-14215		MARIE B. BOYD 1009 CHillum Rd #315 Hyattsville, Md.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Metastatic carcinoma</u> <u>1538</u> DUE TO, OR AS A CONSEQUENCE OF <u>Carcinoma of colon</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF _____ (c) _____										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH over 8 mo.	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <u>1538</u>											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No. City or Town County State							
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE <u>John Kehoe</u> M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>				22b. DATE SIGNED			
EXAMINER'S NAME (Type) John Kehoe MD Riverdale, Md.				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>				7-15-68			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>				ADDRESS (Street, city, town, or county)			
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)					
Burial		7-18-68		Ft. Lincoln Cemetery		WASH. D.C.					
24. FUNERAL DIRECTOR ADDRESS						25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE			
W.W. Chambers Co. Inc. Riverdale, Md.						DATE JUL 18 1968		J Charles Judge			



825 81100

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MEDICAL CERTIFICATION

1. DECEASED-NAME (Type or Print) JOHN V YEAGER										2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> Month July Day 3 Year 1968		2b. HOUR M			
3. SEX M		4. RACE W		5. DATE OF BIRTH Sept 5 1898		6. AGE (In years last birthday) 69 YRS.		IF UNDER 1 YEAR MONTHS DAYS 		IF UNDER 24 HRS HOURS MIN. 		2c. DATE PRONOUNCED DEAD July 3 Year 1968		2d. HOUR 12:00 M	
7a. BIRTHPLACE (State or foreign country) DC				7b. CITIZEN OF WHAT COUNTRY? USA				8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				9. COUNTY OF DEATH Prince Georges Md.			
10. CITY OR TOWN OF DEATH Cheverly				11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Prince Georges Gen Hospital				12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Los Light				12b. KIND OF BUSINESS OR INDUSTRY Los Light			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Md				13b. COUNTY Pr Geo Mt Rainier				13c. CITY OR TOWN Pr Geo Mt Rainier		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 3111 Window Rd			
14. FATHER'S NAME First John Middle V Last Yeager Sr				15. MOTHER'S MAIDEN NAME First Minnie Middle Zigler Last Zigler											
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No				16b. SOCIAL SECURITY NO. 577 677311				17. INFORMANT Son Ronald J Yeager				ADDRESS 7741 Riverdale Rd New Carrollton Md			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Thrombosis DUE TO, OR AS A CONSEQUENCE OF 4109 (Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.) (b) Coronary arteriosclerosis DUE TO, OR AS A CONSEQUENCE OF years (c) few minutes												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 4201															
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?								20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>				21b. TIME OF INJURY Month, Day, Year 19 HOUR A.M. P.M. 				21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)							
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)				21f. LOCATION Street or R.F.D. No. City or Town County State 							
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>															
ACTUAL SIGNATURE Dayton O Watkins				EXAMINER'S NAME (Type) DAYTON O WATKINS				CHIEF MEDICAL EXAMINER <input type="checkbox"/>				5318 Annabaldie			
								ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>				22b. DATE SIGNED Bladenburg Md			
								DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>				7-3-68			
								ADDRESS (Street, city, town, or county) 							
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 7-6-1968		23c. NAME OF CEMETERY OR CREMATORY Mt Olivet Cemetery				23d. LOCATION (City or Town) (County) (State) Washington, D.C.							
24. FUNERAL DIRECTOR Nalley Funeral Home Mt. Rainier, Md.				ADDRESS 				25a. REC'D BY REGISTRAR AUL - 8 1968		25b. REGISTRAR'S SIGNATURE J Charles Judge					

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